ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(PART 1—MEDICARE PROGRAM)

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

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ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(Part 1—Medicare Program)

TUESDAY, FEBRUARY 17, 1970

HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10 a.m. in room 2203, Rayburn House Office Building, Hon. L. H. Fountain, chairman of the subcommittee, presiding.

Present: Representatives L. H. Fountain, Florence P. Dwyer, and Guy Vander Jagt.

Staff members present: James R. Naughton, counsel; Dr. D. C. Goldberg, professional staff member; and Thomas H. Saunders, minority staff.

Mr. FOUNTAIN. Let the committee come to order and the record show that a quorum is present for the purpose of taking testimony.

Under the rules of the House of Representatives, the Committee on Government Operations has responsibility for examining the operation of Government activities at all levels with respect to economy and efficiency. That responsibility, insofar as it relates to the operations of the Department of Health, Education, and Welfare and certain other agencies, has been assigned by the Committee to the Intergovernmental Relations Subcommittee.

Pursuant to this responsibility, the subcommittee is examining the administration by the Department of Health, Education, and Welfare of the Medicare and Medicaid programs. Today's hearing—and a second hearing later this week—will be concerned primarily with part A of medicare—the hospital insurance program.

Before we hear from our witnesses, I think it might be appropriate for me to make some brief observations on national health care expenditures, with particular reference to expenditures for hospital care. As all of us are painfully aware, expenditures for health care have increased tremendously in recent years. According to HEW estimates, total national expenditures for health care in fiscal 1969 were $60.3 billion—6.7 percent of the gross national product.

By comparison, expenditures in fiscal 1950 were estimated at $12.1 billion—4.6 percent of the GNP for that period. As recently as fiscal 1965—just before the medicare and medicaid programs began—estimated health care expenditures were $38.9 billion, an amount which constituted 5.9 percent of the GNP at that time.

Estimated expenditures for personal health care furnished to individuals during fiscal 1969 were $52.6 billion, with the remainder of the national total being expended primarily for reseach and construction. Of the $52.6 billion spent for personal health care, an estimated $22.5 billion (43 percent of the total) was expended for hospital care, $11.9 billion—23 percent—was spent for physicians' services. Drugs, services of nurses and other health professionals, nursing home care, dental care and other health services accounted for the remainder.

About half of the $22.5 billion spent for hospital care was financed by public funds through the medicare and medicaid programs and the provision of care in Federal, State and other government hospitals. It is estimated that about three-fourths of the other half was paid for by Blue Cross and other private insurance programs. Less than 15 percent of all expenditures for hospital care, according to HEW estimates, were paid directly by the persons receiving this care.

Obviously, the manner in which Government agencies and private health insurance organizations make expenditures for hospital care has—and will continue to have—far more influence on the cost of such care than the relatively small percentage directly paid by persons receiving hospital care.

The subcommittee, through its staff and with the assistance of the General Accounting Office, has done a considerable amount of work in preparation for these hearings. In this connection, we have paid close attention to the work being done by the Senate Finance Committee and the House Ways and Means Committee with respect to the medicare program in order to avoid any unnecessary duplication.

The Bureau of Health Insurance of the Social Security Administration has direct responsibility for administering the medicare program. Mr. Thomas Tierney, Director of the Bureau, and members of his staff will be our witnesses today.

Before we start, Mr. Tierney, I want to yield to the gentlewoman from New Jersey, after which we would like for you to identify those who are with you.

Mrs. Dwyer.

Mrs. DWYER. Thank you.

I am pleased we are beginning a series of hearings today which I am sure will result in an objective and nonpartisan review of the operating procedures of the medicare program. Our purpose, I believe, is to suggest reform, reform which will encourage and foster better medical care at minimum cost.

This is a very fitting subject for investigation by our subcommittee, for preliminary study has revealed that a great deal of the trouble with the medicare program emanates from cumbersome, if not deficient, administration and management.

The Government Operations Committee, by its very charter, has particular responsibility and concern for the economic and effective operation of federally administered programs and especially where the welfare of the millions of Americans is directly concerned, this committee has a mandate to assure that federally operated programs function in such a manner as to provide a maximum service to the American public at a minimum cost and effort.

Many Federal programs, of which medicare is no exception, embody

the highest purposes and noblest ideals of improving the quality of life for the American public.

But new concepts, which medicare certainly was in 1965, when translated into operating programs under the Federal Government must necessarily endure a period of trial and adjustment.

But it seems with medicare that some waste and outrageous abuses have been reported and have been encouraged by the manner in which aspects of the program had been administered. The lack of uniform safety standards applicable to all extended care facilities under the medicare program, the lack of effective auditing procedures, confusion over a meaningful, reasonable cost formula and questions of eligibility under the program are just a few of the areas in which I am particularly concerned.

As we look into the operations of the medicare program, I hope that we will identify what abuses do exist to determine just how widespread they are and pinpoint the reasons why they have been permitted to continue.

Thank you, Mr. Chairman.

Mr. FOUNTAIN. I might add for the record that Mrs. Dwyer has been extremely concerned for some time about this area in which we are now beginning hearings.

Mr. Tierney, would you now introduce those who are with you and tell us for the record what their responsibilities are.

STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, SOCIAL SECURITY ADMINISTRATION, BUREAU OF HEALTH INSURANCE; ACCOMPANIED BY HENRY HEHIR, CHIEF, PROGRAM INTEGRITY STAFF; MANUEL LEVINE, CHIEF, DETERMINATIONS REVIEW STAFF; MORRIS LEVY, ASSISTANT BUREAU DIRECTOR, DIVISION OF STATE OPERATIONS; ROBERT MAYNE, ASSISTANT BUREAU DIRECTOR, DIVISION OF INTERMEDIARY OPERATIONS; MORRIS OLDER, DEPUTY ASSISTANT BUREAU DIRECTOR, DIVISION OF REIMBURSEMENT; JAMES RILEY, CHIEF, COST ANALYSIS SECTION; IRWIN WOLKSTEIN, ASSISTANT BUREAU DIRECTOR, DIVISION OF POLICY AND STANDARDS; AND W. N. HENRY, ASSISTANT DIRECTOR, AUDIT AGENCY

Mr. TIERNEY. Thank you, Mr. Chairman, I will. I have here at the table with me Mr. Robert Mayne, who is our Assistant Director of the Bureau in charge of Intermediary Operations.

And on my right is Mr. Irwin Wolkstein who is Assistant Bureau Director in Charge of the Division of Policy and Standards.

I also furnished to Mr. Naughton a list of the other people who are here and are prepared to be responsive to the subcommittee's questions.

Mr. Henry Hehir, the Chief of the program integrity staff.

Mr. Manuel Levine, Chief of the determinations review staff.

Mr. Morris Levy, Assistant Bureau Director, Division of State Operations.

Mr. Morris Older, Deputy Assistant Bureau Director in the Division of Reimbursement.

Mr. James Riley, Chief of the Cost Analysis Section in the Division of Reimbursement.

Mr. Silverman, who is listed on the list of witnesses, is undergoing some minor surgery today and will not be here, but hopefully will be here on Thursday.

We also have Mr. W. N. Henry, who is the Assistant Director of the HEW Audit Agency assigned to the medicare program by the Audit Agency.

We have a number of other members of my staff, Mr. Chairman, who will be available. We wanted to be totally responsive to the questions you might have.

Mr. FOUNTAIN. We appreciate your presence here this morning and your cooperation. We try to operate these hearings in an informal way to whatever extent we can, so as to avoid any waste of time. I understand you have a prepared statement.

Mr. TIERNEY. I didn't know whether or not the subcommittee would want a prepared statement. I did prepare one, but I would prefer, if it meets with your approval, Mr. Chairman, to highlight the summary. I know your time is limited.

Mr. FOUNTAIN. All right, we will be glad to have you do that. And we will make your statement part of the record unless some members prefer the statement be read. Is there any objection to that procedure?

If not, it is so ordered.

(The complete statement follows:)

PREPARED STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION

Mr. Chairman and members of the subcommittee, I welcome this opportunity to appear before this committee to discuss some of the operations of the medicare program. As you will recall, medicare consists of the application of the social insurance principles embodied in the social security program to the problem of financing medical care for the Nation's older people. Medicare has gained from its partnership with the successful and popular cash-benefit program under social security, and in turn has made a substantial contribution to the financial security of the aged. At the same time, medicare has confronted those who administer the social security program with the necessity of working with the country's existing medical care system. The mission of the medicare program is not defined as being merely to pay out funds to satisfy the liability of the aged for the cost of care. Medicare also has statutory responsibilities related to the cost and quality of the care it pays for. Thus, the medicare program is one of the parties that must deal with the issues that have become so prominent in the last few years, as the very sharp rise in medical prices has led to public awareness of serious problems in the medical care system.

Administrative organization of medicare

While medicare is financed through Federal taxes and the overall direction of the program is the job of the Social Security Administration, direct contact with those who provide medical care is handled almost entirely through private agents—Blue Cross, Blue Shield or commercial insurers, some 180 in total, as well as many private auditors who are subcontractors, and State agencies. One of the intricate and delicate administrative duties of the Bureau of Health Insurance which I head is to try to assure that these somewhat autonomous organizations pay bills properly and promptly; monitor the quality of hospitals, extended care facilities, and home health agencies; measure the reasonable costs of these providers of services; determine what charges of physicians and others are reasonable; and carry out the various other day-to-day tasks for which they are responsible.

Organization of medical care

One of the problems of dealing well with medical care is that it is composed of a large number of relatively small independently operating units, each with its own characteristics. There are some 7,000 hospitals, 4,000 extended care facilities, 2,300 home health agencies, 2,600 laboratories, 200,000 physicians, as well as substantial numbers of other health service providers. It is a very difficult task to obtain sufficient information about these providers to take the actions appropriate to dealing with each of them. One of the most difficult initial operations of medicare was to develop a system to integrate these separate elements into a whole capable of dealing with a tremendous number of claims. The 6 million hospital claims paid in a year are dwarfed by the 38 million claims paid for medical services. The health benefits paid totaled some $6.3 billion in the last year.

Increasing cost

Previously I referred to the recent sharp rise in medical care costs. This increase is the result of many different factors including the fact that medical care is what is known as a labor intensive industry, with relatively small potential for substituting machines for human hands to increase productivity. Furthermore, until recently employees in hospitals and many other segments of the health industry were not organized in labor unions and were not protected by minimum wage laws and generally were paid less than employees elsewhere. There has been considerable catch-up recently. Moreover, there has been an increasing input of scientific advances in medical care that has required not only added capital but also additional labor to apply it. The financial aspects of medical care have no doubt also contributed to the price rise. Increasingly, consumers of medical care are not directly concerned with the price because it is paid for by insurance or Government. There may be a tendency, too, for some hospitals to exercise insufficient controls over their expenses because they believe that any expenses they incur will be met by insurers without substantial question. All of these and other factors have contributed to the fact that hospital care costs per day have risen not only in the United States but all over the world. The yearly increase in hospital costs in the United States has been as much as 15 percent on an average per-patient-day basis.

These cost rises have affected not only medicare and medicaid but all insurance programs, public or private. The insurance plans for Federal employees are one example. The increase in premiums for family coverage under the high option service benefit—Blue Cross-Blue Shield—plan for Federal employees was 61 percent from January 1966 to January 1970. The corresponding indemnity plan premium rose by 73 percent in the same period.

System for administrative control and self-improvement

The fact that medicare would involve very special problems of administration did not go unrecognized even in the earliest stages of the program. In medical care administration we believe the mark of a successful program is not the total elimination of all problems but rather identification of the problems as early as possible and vigorous action to try to relieve them. A number of decisions were made at the outset of the program, some before the first benefit was paid, to prepare us to identify problems as they arose, whether they involved only individual cases or were of a more general nature. Most elements of our system of administrative controls were planned over 4 years ago, although not all of them could be translated into processes and systems immediately.

A major element of control in a far-flung, many-faceted, decentralized system of administration like that of medicare is the development of operating statistics that permits comparison and analysis of the entire process. Before any claims were received, a system was developed for obtaining uniform and reliable program data from intermediaries, carriers, and States about hospitals, extended care facilities, doctors and other suppliers of health services. While the system was designed before July 1, 1966, data of this kind—for example, data on extended care facility costs—take a long time to be produced and made available for analysis. The first year of coverage of extended care facilities was 1967. Annual costs could not be made available until 1968. Many extended care facilities had never become very expert at cost accounting, the intermediaries were new at the job, the auditors that were used by medicare were unfamiliar with the medicare rules. To get through the process of preparing cost reports which could be said to be accurate, even when judged by only

the most basic criteria of good accounting, was no quick and easy job. The intermediaries rejected many on desk review for any number of reasons. Auditors found all kinds of difficulties and in some cases had to reconstruct the records in their entirety to produce a report. After they were through, the intermediary in the case went to the provider to settle differences between the report as submitted and the corrected one the intermediary though more proper. After that was over, in many cases the national Blue Cross Association, when it examined the final report, found obvious deficiencies and required another reworking.

All of this has meant that only in 1969 did the first data of any consequence begin to flow to us on the final cost settlements of extended care facilities. Yet the system design still seems sound and appropriate for the program as enacted. We will be analyzing and comparing the reports as received, and we will be taking actions as indicated by our findings. We hope and expect that the system will be improved in the future as the experience of extended care facilities, intermediaries, and our own staff are assimilated into the process, and we find and eliminate kinks in our policies and procedures.

Another example of anticipation and realization built into the medicare systems has been our identification of physicians to whom substantial sums were paid under medicare. At the earliest point in our organization, we set up in our computer processing in Baltimore a basis for accumulating the total in claims paid by physician. The first tabulation of the results of this accumulation was made in 1968 and it produced some results in identifying problem situations that verified our opinion that such data collection was most worthwhile. As a result, we prepared to do an extensive tabulation of the 1968 payment information. This information was requested by the Senate Finance Committee and was the basis for some of the staff findings about which I am sure you have heard.

Surveillance of intermediaries and carriers

Another facet of our management control system is related to surveillance and improvement of intermediaries and carriers. As would be expected, financial control is achieved in part through a budget process. Under the budget system, annual and quarterly claims workload estimates form the core of the budgeting process. In addition to the costs involved in claims processing, intermediaries and carriers have costs related to their other responsibilities which do not lend themselves so readily to precise measurement. These include provider and professional relations, utilization review, beneficiary services, and, most important from a cost standpoint, audits of providers. Provider audits are generally done by independent accounting firms under subcontract with the intermediaries.

Intermediaries and carriers are required to submit detailed justifications with their annual budget estimates which sufficiently explain the proposed use of funds requested. Items of possible expenditure must be explained fully and are considered in the light of estimated workloads and productivity.

When budget analysis is completed, intermediaries and carriers are granted annual budget approvals which are apportioned on a quarterly basis. They are required to plan their operations within these annual and quarterly allocations and are not permitted to incur expenses in excess of them without written authorization.

Under the cost reporting system, each intermediary and carrier is required to submit quarterly cost statements and final annual cost reports based on its accounting year. The quarterly reports reflect actual administrative costs distributed functionally. In addition, they report total benefits paid and workloads processed during the period. These are reviewed in relation to such factors as manpower use, productivity, cost per claim, and the ratio of administrative costs to benefit payments. Significant deviations of incurred cost from the approved budget must be explained.

Final cost reports form the basis for audit and final cost settlement each year and are, therefore, submitted in greater detail. All of the information contained in the quarterly reports is included in these annual reports and, in addition, a detailed justification of proposed expenditures much like that required for budget estimates must be submitted. All pertinent information which has been accumulated about each intermediary and carrier becomes part of the contract reporting and monitoring system used to coordinate the entire system.

Contract reporting and monitoring system

The various workload and financial reports which intermediaries and carriers are required to submit for a reporting period permit the evaluation of their operations and cost required for those operations. Workload reports reflect not only the quantity of work being done but also the timeliness of performance. Quantity of production is measured in terms of units received and units cleared. Currency of performance is measured in terms of claims awaiting action and the time required to complete them. Promptness is also measured in terms of the number and proportion of cases awaiting action for an unusual length of time (e.g., over 30 days) in relation to total pending cases. Complexity of workload is indicated by the distribution of claims by type, and the number of cases which must be returned for additional information or documentation before payment may be made. The monitoring system provides pertinent data for each intermediary and carrier and permits the computation of national averages for comparison purposes. When significant disparities between individual performance and national averages are identified, necessary corrective action is undertaken.

Audits of intermediaries and carriers

The DHEW Audit Agency examines intermediary and carrier medicare operations. Although the primary purpose of the audits conducted by the audit agency is to review and approve administrative costs, the scope of these audits is not limited to financial considerations. In addition to verifying financial transactions, auditors verify that funds were spent according to law, regulations, and procedures, and they consider whether policies, plans, and procedures are adequate for effectvie operations.

Contract performance review

Teams from the Social Security Administration visit intermediaries and carriers to review their performance. The review team spends 3 to 5 days with the intermediary or carrier, observing and analyzing operating procedures, examining records, and interviewing personnel at all levels. The teams make a detailed examination of organization for performance of medicare functions, staffing of medicare positions, personnel and management practices, and claims processing techniques. The team also assesses the effectiveness of the application of reimbursement principles, professional relations, beneficiary services, training, as well as the adequacy of space and equipment. Other aspects of performance are also included as may be considered appropriate in the particular situation.

A recent addition to this control process has involved the stationing of resident representatives of the Bureau of Health Insurance at the offices of many of the larger carriers and intermediaries to obtain immediate, firsthand information on the situation at hand and on changes that occur and to provide immediate consultation and direction.

I will mention briefly a few more of the administrative control devices adopted at the outset of the program. Too important to omit was the decision to provide for centralized development of policy and procedure. It was decided that central policy control was to be the basic method of operation, even though it was not possible to develop before the program became operational all the details of policy and procedure that would ultimately be desirable. Policy statements were made available in manual and letter form from the program's outset, and these have been elaborated on and improved as time has passed.

Furthermore, a systematic postpayment review of claims was required to be carried out by each intermediary and carrier, and claims were required to be submitted to central office on a sample basis for statistical analysis.

Finally, a system was developed so that beneficiaries would be informed of claims paid in their behalf no matter who received the payment. One of the results expected from this process was that beneficiaries would inform the program where they thought an improper payment had been made, thus providing a source of evidence of possible fraud and also consequently a deterrent to claims for services not rendered or for higher charges than were actually made.

In summary, let me say that we believe the medicare program is a good program—well conceived by the Congress—and well administered by the Social Security Administration. It was a massive undertaking and continues to be a massive operation. It can be improved, we believe, both through legislative amendment and administrative action. In retrospect, perhaps some other priorities of activity would have been desirable. For the future our goal is a maximum of efficiency and effectiveness.

Mr. TIERNEY. First of all, Mr. Chairman and members of the subcommittee, we welcome this opportunity to appear before you and discuss some of the operations of the medicare program.

As you well know, medicare is basically a health insurance system designed by the Congress to remove the financial impediment which stands in the way of older people seeking high quality comprehensive health care. Their age and their income status distinguishes them from most of the rest of the population. They use on the average about two and a half times as much health care as do people under 65, and this need for care comes at a time in life when their financial status is either static or substantially depleted. So, the Congress conceived, quite appropriately, that this would be an insurance program in the broad spectrum of the social insurance programs administered by the Social Security Administration.

The program is financed, as you are aware, through Federal taxes and payroll taxes for part A and premium payments and general revenue appropriations for part B, which is the physician's services portion of the program.

As you noted in your opening statement, the primary responsibility for administration is vested in the Social Security Administration and its Bureau of Health Insurance. I suppose there have been few Federal programs, however, which have tried to integrate into administrative operations as many and as diverse and separate a number of administrative agencies. On the part A side, in which you have expressed your primary interest in these hearings, we deal with some 83 fiscal intermediaries—either Blue Cross plans or commercial insurance companies. We deal on the part B side with 33 Blue Shield plans and 16 commercial companies. The Congress, not only in the act but in the Committee reports, made it very clear that a major portion of the administrative activity of the program would be carried on by these organizations, so we have operated in that manner. Obviously, it has some very great advantages, obviously some disadvantages.

Another indication of the scope of the operation of the program is that we are dealing, either directly or indirectly, with a tremendous number of relatively small and independently operating health care organizations. We have participating in the program some 7,000 hospitals across the country, over 4,000 extended care facilities embodying a concept which was really created by Congress. It brought them into being. In addition, there are some 2,300 home health agencies, 2,600 independent laboratories and 200,000 physicians, and, of course, a number of other health service providers. Through the carriers and the intermediaries we processed and paid some 6 million claims in the most recent year, under the part A portion of the program and over 38 million claims for medical services under part B.

The total health benefits paid in the last fiscal year amounted to about $6.3 billion. Just to give you some perspective on what those figures mean, all of the independently operating 76 Blue Cross plans in the country and some 60 or more Blue Shield plans, after 30 years of operations and after 30 years of perfecting techniques, mechanisms and procedures, claims processing, audit and what not, do just about that same amount of business for their entire operation throughout the country.

In other words, medicare in a very short period of time is matching the operations of all of those organizations. There is no question, Mr. Chairman, but that the figures you cited are figures which are of tremendous concern, I think not only to medicare and medicaid but to the entire public today.

The increase in medical care costs is unprecedented; the increase in hospital costs is accelerating, at an even higher rate than medical care costs generally. I think it is interesting to note, perhaps again to give some perspective to the problems which we face, that medicare and medicaid are not alone facing the problems caused by this ever-increasing cost of health care.

The premiums, for example, for high option family coverage in the Federal employee health insurance program, which you may or may not be familiar with, have risen 61 percent on the Blue Cross-Blue Shield side from 1966 through January 1970. And on the indemnity program they have risen 73 percent. In the most widely held Blue Cross group plan in Maryland, premium rates have risen 64 percent. So, all segments of the health industry and the health prepayment industry are suffering to a very large degree from the same problems that we face, although they do not have the same type of complex operation.

I have included in my statement for your information, Mr. Chairman, some of the systems we have identified and put into operation for administrative control and for review and surveillance of carrier and intermediary performance.

We deal, for example, with 50 State health departments in the certification of facilities. I don't think I will go into those in detail because I assume during the course of your hearings you will be asking us for further detailed information about them.

Let me say in summary, Mr. Chairman, that I certainly concur with Mrs. Dwyer's statement. We believe the Medicare program is a good program. It was well conceived by the Congress, and we think it has been well administered to date. That is not to say it hasn't been without its problems. It was a massive undertaking and continues to be a massive operation. It can undoubtedly be improved both through legislative and further administrative action. I suppose in retrospect any objective observer might have established a different set of priorities of administrative activities than those which we established, but we think they have been effective and are constantly being improved. So, I share your goal and your stated objective of introducing into the program a maximum of efficiency and effectiveness.

Mr. FOUNTAIN. Thank you, Mr. Tierney.

I wonder if you would give us some information about your own background and previous experience for the record and for the benefit of members of the committee?

Mr. TIERNEY. Yes, sir.

I am a third generation native of the beautiful State of Colorado. There weren't very many people but Indians around there before that time.

I went to the University of Notre Dame, graduated from the University of Denver and the Denver University Law School.

I was in the Armed Forces for 4½ years in World War II. I then practiced law in Denver for about 11 years. In the course of

that practice, I became associated with Blue Cross first, as a representative of a hospital on the Blue Cross Board, and ultimately as head of the Blue Cross organization in Colorado, a job which I held for 10 years.

At the time of the institution of the Medicare program, I was recruited by the Commissioner of Social Security to my present job.

Mr. FOUNTAIN. How long have you been Director of the Bureau of Health Insurance?

Mr. TIERNEY. I went on duty, Mr. Chairman, on April 15, 1967.

Mr. FOUNTAIN. Does the Bureau of Health Insurance have sole responsibility for operating the medicare program or are there functions performed by HEW personnel outside of the bureau and if so, would you give us the details?

Mr. TIERNEY. The Bureau of Health Insurance has basic responsibility for the on-going routine operations of the program, Mr. Chairman. We are aided and assisted in this by a number of agencies in HEW. Perhaps one of the most significant areas is in the development of conditions of participation for institutional providers in which a very large amount of the input is provided by the Public Health Service for obvious reasons of their professional competence.

There is a mass of data processing involved in a program of the size I am talking about and we do not operate our own data processing operation. This is taken on by the Bureau of Data Processing and Accounts in the Social Security Administration.

The compilation of most statistical data of the program, other than on-going continuing reports we get from intermediaries and carriers and other administrative agencies is largely in the Office of Research and Statistics of the Social Security Administration.

I think those are the major inputs, Mr. Chairman, of agencies other than the bureau.

Mr. FOUNTAIN. In addition to Mr. Ball, the Administrator, are there any other officials in the Social Security Administration above you in the chain of command?

Mr. TIERNEY. Yes; Mr. Ball is the Commissioner of Social Security, Mr. Arthur Hess is the Deputy Commissioner of Social Security.

The Administration is involved or is organized along the lines of business and offices. The operating functions are carried on by bureaus. There is the Bureau of Retirement and Survivors Insurance, the Bureau of Disability Insurance, the Bureau of Hearings and Appeals, the Bureau of Data Processing and Accounts, the Bureau of Health Insurance, the Bureau of District Office Operations.

The other offices are the Offices of the Actuary, the Office, as I told you, of Research and Statistics, the Office of Administration. But as far as the chain of command of medicare, it goes from me through Mr. Hess to Mr. Ball and from Mr. Ball to the Secretary.

Mr. FOUNTAIN. To what extent is the work of the Bureau of Health Insurance supervised by your superiors in Social Security and by officials of the Department of Health, Education, and Welfare?

Mr. TIERNEY. Well, Mr. Fountain, in the routine daily administration and operation of the program, there is little supervision. In the development of longer range policy, longer range procedures, obviously the Commissioner and in many cases the Under Secretary's office or the Secretary's office are involved in major decisions.

Mr. Wolkstein is our Assistant Bureau Director in charge of Policies and Standards but the making of fundamental policy is something that we have a great deal of participation in. Obviously to the extent that they are important, particularly, it is an ultimate decision a little higher up.

Mr. FOUNTAIN. How many employees does the Bureau of Health Insurance have?

Mr. TIERNEY. I have a breakdown of them.

Mr. Chairman, we have a total of 1,195 employees across the country. Now, 685 of those are professional or semiprofessional employees, the others being clerical; 685 are at the GS–11 level or above.

If you would like a breakdown on them, there are 45 in our direct reimbursement branch. One of the provisions of the law is that providers are authorized to nominate an intermediary and most of them nominated intermediaries from the private sector. However, they were given the right to deal directly with the Social Security Administration if they chose to. So 45 of these people are involved in that operating organization.

We have 162 people out in the field offices. We have 9 regional offices around the country. So 162 of this number are there. Ninety-nine of them are in Mr. Mayne's Division of Intermediary Operations, 85 in Mr. Wolkstein's division, 50 in State operations, which has primary responsibility for surveillance in dealing with the State health departments and 57 in the Division of Reimbursement.

I have, Mr. Chairman, if you would find it interesting, a very simple organizational chart of the Bureau.

Mr. FOUNTAIN. We would like very much to have that for the benefit of the committee.

How does that total number, 1,198, I believe you said, compare with the total number of people employed by the Social Security Administration?

Mr. TIERNEY. At the present time, there are 50,336 full-time permanent positions in the Social Security Administration.

Now, if you would like a breakdown on those, the Bureau of District Office Operations, as you well know, maintains some 758 district offices all over the country, in addition to some administrative centers elsewhere. 20,250 of those people work in the District Office Operations. 12,454 work in the Bureau of Retirement and Survivor Insurance. That is the cash benefit program and as you know there are some 24 million beneficiaries who receive a cash benefit of one sort or another each month. 8,545 work in the Bureau of Data Processing, 4,110 work in the Bureau of Disability Insurance. Upwards of 2 million people either directly or of dependents are drawing monthly disability benefits. 1,236 employees work in the Bureau of Hearings and Appeals.

So we are the smallest of the bureaus from the standpoint of personnel but other bureaus have, in effect, much larger administrative tasks than we because so much of the actual administrative operation is contracted out in our operation.

Mr. FOUNTAIN. How many employees do the intermediaries have working with medicare?

Mr. TIERNEY. I don't have precise data. I have a figure in mind that

the intermediaries and carriers combined have about 16,000 people. I can get you the precise number.

Mr. FOUNTAIN. Thank you.

Mr. NAUGHTON. Are there about 6,000 working on part A, the hospital level?

Mr. TIERNEY. I think that is about right, Mr. Naughton.

Mr. FOUNTAIN. If you have that breakdown, we would like to include it in the record.

Mr. TIERNEY. Yes, we will supply that.

(The following information was subsequently supplied:)

Intermediary employees working on part A of medicare—6,456; carrier employees working on part B of medicare—12,478, for a total of 18,934.

Mr. FOUNTAIN. Mr. Tierney, I might preface this question by saying I am sure we all feel we can use more people to do our job. But I would like a candid opinion from you as to whether or not you have sufficient employees and other resources to properly administer the medicare program?

Mr. TIERNEY. First of all, I would agree with your basic premise, Mr. Chairman, that we could always use more people.

We are currently recruiting a considerable increase in personnel, particularly in our field offices. I think one thing that is emerging from a purely administrative point of view as this program matures is that it is so widespread and so many different elements play a role in it that it can't really be controlled adequately from a central office.

We are therefore continuing to build up our field operations. For example, we now have a program underway whereby we will have an onsite representative in the office of every intermediary and carrier in the country. We tried during the beginning stages of this program to carry on that surveillance through contract review teams going out to visit the intermediaries and carriers. Mr. Henry's HEW audit agency of course conducts the audits of their operations. We have done a number of things to try to keep on top of it. But we think the ultimate is to have a man onsite who can identify problems quickly and call them to our attention. So in that area we have secured approval and are recruiting and I hope within another 6 months we will have accomplished the placing of people on site in every single operation. This I believe is a real need.

Other than that, Mr. Chairman, yes, we can always use more people and more importantly skilled people. But I think we have had a fair apportionment of personnel from the administration. As you well know, the total Federal executive branch is under some rather strict limitations on staffing, but we have had our fair share.

Mr. FOUNTAIN. Are there any areas of responsibility within your program where you feel you have too many? You know sometimes people get in one another's way and nobody accomplishes anything?

Mr. TIERNEY. No, I don't think we have too many, I think again we are learning through experience. We set this program up pretty much in a vacuum. There wasn't any medicare program so you tried to figure out what it should be. You were going to have intermediary operations, dealing with States, you were obviously going to have to develop policies and standards, this direct reimbursement branch and obviously an accounting branch.

So we went along those lines. We are currently taking a long look at the total structure to make sure there are not better ways to organize. I think as the program matures, Mr. Chairman, it becomes more apparent that we do have three major areas of responsibility.

One is the establishment of standards and policies and I think this is a national operation. The other is the development of relationships among all of the different entities who deal with the program. Third, a concentration of effort both through the central and more particularly through the regional offices on day to day observation and surveillance, if you will, of the program.

So it is possible that type of organization will emerge rather than the present divisions we have.

Mr. FOUNTAIN. I might say in connection with any of my questions, I'm not attempting to express an opinion by the question but to place on the record the facts that the Congress needs.

Have you ever requested additional personnel and been turned down and, if so, why don't you give us the details?

Mr. TIERNEY. I don't think I could give you details on that, Mr. Chairman. There have been times when the administration was simply under a ceiling limit where there could be no further personnel in a given month. It may be that we requested replacements and there were none available and we had to wait in line. But I would say in answer to your question we have never made any major requests for a substantial increase in personnel and been turned down.

Now, the job of recruiting some of these people, Mr. Chairman, for example the onsite representatives, is difficult. It is fine to say we are going to put somebody onsite. But this man is going to walk into an operation, for example, like Associated Hospital Service in New York, which is the biggest Blue Cross plan in the Nation, and he is to be responsible for opening that operation and all of its facets, its data processing, auditing, methods of payment and be meaningfully involved in an analysis of the quality of performance. This is a pretty smart guy.

You don't just pick up anybody to try to undertake that kind of a job. So the recruiting has been a pretty long and painful process.

Mr. FOUNTAIN. Do you have a definite civil service requirement for these kinds of personnel?

Mr. TIERNEY. Yes.

Mr. FOUNTAIN. They take civil service examinations?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Do I understand from your testimony, Mr. Tierney, that the lack of sufficient quantity of personnel has not been a significant problem in the administration of the medicare program, as to the total number you wanted?

Mr. TIERNEY. Mr. Naughton, I know you have been concerned and rightly so, as we are, about the whole problem of obtaining cost reports and auditing them properly.

There is no question but that we could use more people in this area on a followup basis. However, as you well know, the job of cost auditing is one that is delegated to intermediaries and I should have made that point, Mr. Chairman, in reply to your question.

In addition to the people working directly for the intermediaries, they have largely contracted out to some 200 private auditing firms,

most of them, the great bulk of the auditing being done by the so-called big eight outfits, Price, Waterhouse and the like.

They have another 2,000 to 3,000 people out doing the actual audits. So Mr. Naughton, we could use more people to effectively follow up but I am not sure that simply more people in the Bureau of Health Insurance would hasten the cost reporting and audit cycle.

Mr. NAUGHTON. But denial of requests for quantity of personnel has not been a great factor in any problems you may have. This is what I drew from your testimony.

Mr. TIERNEY. Yes, I think that is correct.

Mr. NAUGHTON. You have something less than 2,000 people working in the Bureau of Health Insurance——

Mr. TIERNEY. I have heard that said.

Mr. NAUGHTON. Have you ever had any problem in terms of your requesting or your predecessor requesting that personnel and resources of the Social Security Administration outside of your own shop be devoted to solving the problems of the medicare program and being turned down or not provided the support that you needed?

Mr. TIERNEY. I dont think we ever have been turned down or not provided the support we have needed but there have been difficult priority situations.

As I said before, there are 24 million people who on the 3d of each month get a social security check from the Bureau of Retirement and Survivors Insurance. People tend to think that once this is established it is very static thing. But there is a tremendous amount of movement in that every month.

People will go on and off the rolls depending on whether they go back to work or not; they move and change.

So while we have a mass of computers there is also a maze of computer operation going on. There have been undoubtedly occasions when we have had to wait in line because the data processing people have had other problems.

As you know the social security cash benefits had been increased by the Congress effective January 1, with some checks going out later. This is a massive undertaking, a tremendous undertaking from the point of view of programming and machine time.

So that at the moment if we wanted any kind of major change in medicare data processing, I am sure we would find it difficult to get it accomplished. As soon as that problem is answered we will get primary attention.

Mr. NAUGHTON. To close this and go on to other things, could you provide for the record a list of any significant occasions or which requests for computer time have not been granted?

Mr. TIERNEY. Yes, I will try to give you that information.

Mr. NAUGHTON. Starting back to the beginning of the program and running on up today.

Mr. TIERNEY. Yes.

(The following statement was supplied for the record:)

A review of requests for use of SSA EDP facilities for Bureau of Health Insurance activities does not reveal an instance where the Bureau was not granted computer time when requested. The basic problems that have been encountered have had to do with the development or refinement of EDP systems involving their

design, programing, validation, and implementation. This has occasioned delays in the following areas:

(1) The establishment of a premium billing and collection system divorced from the master benefit record and payment system. The refinements which have been identified as appropriate to upgrade the system introduced several important policy considerations which involve the concerns of several of the bureaus and which introduce a range of priority considerations in development of systems specifications. Also, some temporary delay in implementation has been occasioned by inability of EDP equipment to provide adequate core memory positions, but this has been resolved.

(2) Refinements in the establishment and maintenance of HI entitlement records dealing with collection of medical insurance premiums from Federal civil service annuities, the coordination of data between SSA and RRB, and the exchange of entitlement data between the master beneficiary record and the HI master record. Again, the matter of obtaining priority attention on the part of all parties involved in developing the detailed systems specifications has been the primary cause of delay. While proposed systems refinements could constitute definite improvements, on an overall priority basis they do not have the urgency for implementation that attaches to other SSA projects.

(3) Implementation of a special EDP system for maintaining and controlling data on compensation paid owners of participating providers has been delayed because of difficulties encountered in assuring that all administrative segments have a full understanding of the problem and that developed systems solutions are satisfactory.

(4) Requests for changes in existing systems have been set aside in several instances because of the impact such changes might have on other existing systems. In situations of this type the range and variety of programing problems that have confronted BDPA staff in making such wide systems revisions have been responsible for delay along with the basic time-consuming factor of working out adjustments acceptable to all constituents.

Mr. Fountain. Mr. Tierney, our next question is one which will give you an opportunity to give us the benefit of your vast experience, particularly your experience during the operation of this program.

The medicare law was enacted more than 4 years ago and the program has now been in operation for more than three and a half years.

Do you feel any mandatory requirements of the law or any lack of necessary legal authority have created serious administrative difficulties? If so, would you give us details?

Mr. Tierney. Yes, Mr. Chairman. I think medicare blazed a lot of new trails in the field of health insurance. Health insurance prior to the institution of the program had largely been hospital centered. Most Blue Cross plans paid for in-patient hospital care, relatively little outpatient care, doctors' surgical procedures, and in-hospital medical care, very little coverage for home and office calls.

The insurance industry generally, as well as Blue Cross, has had extremely limited experience in dealing with nursing homes and absolutely no experience in dealing with this concept of extended care benefits which was again a creature of the medicare law.

We never have had any significant insurance of home health agency services prior to medicare. In fact, there were no home health agencies before medicare, although there were visiting nurse associations which provided a more limited type of care. So that some of the things that were enacted into the law, I think quite appropriately, we really had to start from scratch on.

One of the most difficult administrative functions, I suppose we and the intermediaries are faced with, Mr. Fountain, is in the area of extended care benefits. The law made it quite clear that we were not to cover what was then regarded as nursing home care. As a matter of

fact, there is a specific provision in the law which says, in effect, notwithstanding any other provision of this act, no payments will be made for care which is custodial in nature.

Nursing homes traditionally before medicare had rendered a great deal of custodial care. Under the law, to qualify for benefits in an extended care facility the patient must first of all meet the statutory requirements of having been in the hospital for 3 days and then being admitted to an extended care facility within 14 days because of a continuation of the need for continuous skilled nursing service for the same condition for which the patient was hospitalized.

Now, this involves some rather exquisite medical judgments. Most old people have more than one infirmity; they may have three or four infirmities. An old person without anyone at home to take care of him and who cannot take care of himself totally, but needs help for personal hygiene or clothing and feeding himself, obviously has a need to be institutionalized. But that doesn't necessarily mean he qualifies for extended care benefits under the Social Security Act.

We and intermediaries have had a great deal of difficulty in administering this provision. I don't frankly know, however, Mr. Chairman, what the answer to that problem is other than a continuing job of claims review and education of both doctors and the operators of extended-care facilities.

I think the Congress would find that there may exist a very great social need for some kind of custodial care either in the home or in nursing homes for aged people.

Whether or not that should be appropriately charged against a health insurance program I think is another matter of basic social policy for the Congress to consider, and certainly there is no question but that type of benefit would be extremely expensive. I think the medicaid experience indicated that. So that the program for extended-care benefits is an area of the law which has caused us serious administrative problems. I know you are focusing your attention during these hearings on the part A portion of this program and perhaps therefore wouldn't be as interested at this time at least in the part B portion.

But there are provisions in part B which require many medical judgments and which are difficult to administer, particularly when you are processing 38 to 40 million bills per year. You really cannot conduct a full medical audit on every one of those bills or the administrative expenses would become horrendous.

Yet it is our responsibility to try to see to two things: That the service was medically necessary and secondly that a reasonable charge was made.

Again, with 38 million bills you have to develop some very sophisticated computer technology and techniques in order to really accomplish those things.

I think another provision of the legislation now before the Bureau of the Budget for legislative consideration deals with the problem that the Secretary is really not given any authority under the law to either attach funds or impose liens or anything else in situations where that might be a desirable thing to do because perhaps an overpayment had been made.

We now operate under the Federal Claims Collection Act, under which, if we determine an overpayment has been made, we first make an effort at collection.

If we cannot do it, the case is referred to the General Accounting Office and they in turn make an effort to establish a collection schedule that is appropriate. If that fails, the case is then turned over to the Justice Department for whatever action it might take.

I think this is a bit of legislation that could assist us. Another thing that the law limits us to, Mr. Chairman, is paying reasonable costs. Not only the law but more substantially the committee reports at the time the law was enacted made it clear this was to be reasonable cost without defining reasonable cost in full detail, but nevertheless the reasonable costs incurred by institutions in providing service to medicare beneficiaries, no matter how much those costs might be disparate from the costs of other institutions providing services.

We also, under part B, are charged with the payment of reasonable charges for services. We asked in 1967 and we were given some authority to engage in so-called incentive reimbursement experiments in an effort to see if there weren't incentives which could be built into a reimbursement formula which would go beyond simply the paying of costs and give people incentives for more effective and efficient administration.

We have had a limited response from the field. The law did specify the experiments would have to be voluntary on the part of any providers. We have three experiments going on which we think may bear some fruit. But in the so-called Health Cost Effectiveness Amendments, the Secretary is asking for a broader authority to engage in demonstrations or experimentation.

But in answer to your question, other than that, Mr. Fountain, and recognizing as you do, I am sure, the complexities of the administrative structure, which again is specified by law, the Secretary is required to utilize carriers, and intermediaries and is required to accept the nomination of providers as to who their intermediary will be unless he can make a finding that such a nomination would not be in keeping with efficient and effective operation of the program.

This poses some difficulties but it was quite clear that was the congressional intent. I think, too, I would want to say that while there have been problems in that operation the intermediaries and carriers have done an effective job and from the coldblooded practical point of view, I don't think any other alternative was available at the inception of this program.

There was no Social Security Administration or any other Federal agency that could have undertaken the total claims-processing operation. I don't know whether I have fully responded to your question or not.

Mr. FOUNTAIN. Yes, you have.

Are there any specific changes in the law which you would recommend? Other than those areas you have commented upon?

Mr. TIERNEY. No, sir, I don't have personally any basic legislative proposals. The administration, as you may know, has introduced in the House Ways and Means Committee hearings the so-called Health Cost Effectiveness Amendments of 1969. I don't know whether the

subcommittee has copies of an analysis of those suggestions or not. But they can be made available.

Mr. NAUGHTON. Mr. Tierney, I jotted down six items that I think you mentioned.

The first is the extended care concept; the second relates to part B; the third is authority to attach funds and to place liens upon property of those who have not paid; the fourth is the reasonable costs formula; the fifth is incentive reimbursement and the sixth item is the requirement that you use intermediaries.

Am I correct that on part B, that the administration has requested authority to bar repeated offenders from the part B program?

Mr. TIERNEY. Very true.

Mr. NAUGHTON. This is a little different than a hospital or extended care program where you first approve the provider and if he isn't approved you don't pay any bills under that provider; on the other hand the patient chooses the physician and you don't know where he has been until the bill comes in.

Mr. TIERNEY. That is very true, Mr. Naughton. We can, if an institution fails to live up to the conditions of participation, terminate its participation in the program or if it doesn't meet them in the first place not certify it.

But on the part B side it is an indemnity program and if an old person goes to a doctor who overcharges or overservices him, we have to indemnify the old patient against the charges he has incurred. So we are asking in this cost effectiveness amendment to be given authority to bar such physicians—of course after adequate hearing and all kinds of legal protection—from participation in the program.

At the moment we cannot do that. The legislative proposal also applies to institutions and agencies that provide health services under medicare.

Mr. NAUGHTON. Of the six items, on part B you have requested additional authority and on No. 5 on my list which is incentive reimbursement you have some authority at the present time but the administration has officially requested more, is that correct?

Mr. TIERNEY. Our authority is limited right now to simply depart from the basic cost or charge reimbursement principles of the law with the consent of the institutions or persons that are affected.

What we are seeking now is authority to find out if there aren't better ways of doing this whole job.

One of the things that I think is emerging, this is a personal opinion on my part, Mr. Chairman, this whole concept of retroactive cost reimbursement which has largely been the pattern of payment by the private sector through the years as third-party payment has grown, is that it doesn't provide very great incentives for effective administration of an institution. Under this approach, you start out with a year and when the year is over you pick up whatever the costs were. If the costs were high but nevertheless within the realm of reasonableness, the providers are assured they are going to be covered.

If through imaginative and effective administration a given institution cuts its costs, it doesn't receive more, it receives less.

The whole problem of going back and trying to get cost reports, trying to get all the detail of cost accounting, trying to get audits

performed, trying to get them returned and final settlements made really goes back to the concept of retroactive cost determination.

What we want to experiment with, and I think it may be to the benefit of not only medicare and medicaid but to the whole health system of the Nation, is the possibility of establishing target rates or budget rates or negotiated rates under which you know at the beginning of the year essentially what you are going to pay a given institution and if that institution gains through effective administration, does better than the rate that had been found reasonable, it is fine. Then the institution will profit from the cost reductions.

Like any other business it prospers. If on the other hand, it doesn't do very well in keeping costs within income, it has problems. At the moment we don't have the authority to do all that we would wish, and that is the authority we are seeking.

Mr. NAUGHTON. Of the six items I have, I find two on which recommendations for changes in legislation are currently pending.

Now, on the other four, the first item is the concept of extended care which I understand you say has given you problems and I am sure it does.

Has the administration recommended a change in that concept?

Mr. TIERNEY. No, it hasn't, Mr. Naughton, to date and I think it is a very difficult thing for the administration to make a recommendation.

Mr. NAUGHTON. Has the Bureau of Health Insurance recommended a change to the Social Security Administration or to HEW?

Mr. TIERNEY. No, we have concentrated on trying to make the congressional intent work. I am not sure it cannot be made to work but it cannot be made to work overnight.

One of the alternatives is to say anybody who is under medicare can on a posthospitalization basis go in and have his nursing home care covered. That was not the intent of the Congress. What they were seeking to cover was provision of skilled nursing service that was much like the hospital provides but in a lower cost setting.

I think that is a valid and viable concept but a difficult one to administer. Until we are convinced that it cannot be done, we haven't felt we should recommend it be terminated.

Mrs. DWYER. Is it true that many nursing homes lack skilled nurses to take care of patients?

Mr. TIERNEY. Not in extended care facilities that are qualified under medicare. There are such homes in the Nation.

Mrs. DWYER. But you don't certify them?

Mr. TIERNEY. No, ma'am. There are some 12,000 licensed nursing homes in the Nation. About 4,800 of those participate in the medicare program. In participating homes the State agencies with which we deal certify and recertify that there is adequate nursing service provided.

Mrs. DWYER. How do you know for sure that they don't change their personnel from professional nurses to staff assistants in the interim?

Mr. TIERNEY. The only way we assure ourselves of this is by continued surveillance and visits and checkups. Also we can make a determination from payroll records and this type of thing.

But if what you are asking me is on a given day might an institution for some reason not have the total staff of nurses that is required this

would be difficult for us to discern. But every one of the extended care facilities has been certified by the State health department to meet the minimum nursing requirements.

Mrs. DWYER. Then inspection programs do go on by the States then?

Mr. TIERNEY. Yes, States do the entire certification process for us other than the onsite visits that our regional office people, central office review teams, program integrity staff and other people do.

But the basic certification of meeting the medicare provisions for participation is done by State health departments.

Mrs. DWYER. Do standards differ from State to State?

Mr. TIERNEY. Standards for licensure differ from State to State, yes, but standards for participation in medicare do not differ from State to State.

Mrs. DWYER. Just one more question, Mr. Chairman; how can the Social Security Administration justify the fact that hundreds of medicare cost reports due in mid-1967 have not yet been submitted by participating institutions?

What is the excuse for their not submitting the reports?

Mr. TIERNEY. Let me first correct the statement if I might, Mrs. Dwyer. They haven't been due since 1967. The extended care facility portion of the program didn't start when the rest of the program did. It started on January 1, 1967.

So there were no cost reports due before 1968, the cost reports being submitted on an annual basis.

Let me give you some figures on the current situation, figures that we have given to Mr. Naughton. As of our most recent study and it is right up to date. The last figures—correct me if I am wrong, Mr. Naughton—the last figures we gave you were in mid-1969?

Mr. NAUGHTON. We have the periodic reports you make every quarter.

Mr. TIERNEY. We have 924 delinquent reports at this time. They come from 637 extended care facilities. Let me give you a few facts about these cases. Of those whose cost reports have not been received, 152 of them have had their payments either suspended or reduced, payments have been suspended entirely in 140 cases. Another 177 of them have been referred to our regional offices and they are negotiating collection, 41 of them have been terminated and are no longer in the medicare program or in business; 28 had no medicare business in the fiscal year, so that even though they were certified as providers, they didn't come into the program or never had any patients, so that no report is actually done.

For 23 of them, audits are started even though there were no cost reports.

Let me tell you a little about the problem, if I may. There wasn't a nursing home I don't suppose in this country, which had ever really gone into the kind of cost accounting required by medicare. There was little third-party reimbursement except by welfare programs and that on the basis of charges as far as nursing homes were concerned.

So when the first cost reports were made available to them and filed, we found that in literally hundreds, and I don't think I overstate the case if I say thousands of institutions, they didn't have the vaguest notion of how to fill out the cost reports.

They didn't keep their records that way. So when the first reports came in virtually all of them were unacceptable.

Far from simply auditing cost reports as we originally thought intermediaries would contract with standing firms to do, it became a case of going out and establishing bookkeeping procedures and developing cost reports.

I think the situation is gradually improving. But we have, Mrs. Dwyer, in response to your question, only a couple of things we can do if an outfit is delinquent in filing its reports. We can terminate it, suspend it and thereby take it out of the program, even though it may be filling a real community need, or we can work along with it in trying to establish the figures, trying to upgrade the accounting procedures, trying to get audits completed, trying to get them cleared and carried on.

I think again, as I say, even with 924 outstanding and with it not being really 4½ years but something like 2 years since the reports were due to be filed, that we have made substantial progress.

Mr. VANDER JAGT. Would the Congresswoman yield on that point?

Mrs. DWYER. Yes.

Mr. VANDER JAGT. Would some change in the system of interim payment be an incentive to get their cost reports in? My point being that if a nursing home received an interim payment in excess of that final accounting, there is little incentive to hurry up their costs reports.

Mr. TIERNEY. That is very true. We have been emphasizing this point. For one thing, we recently issued instructions to the intermediaries to the effect that if a cost report is not filed within the 90 days in which it is supposed to be filed, they can, if there is good reason for the delay, allow an additional 30 days to file it. Thereafter they will reduce interim payments by at least 20 percent. I think this will speed things along.

Mr. VANDER JAGT. We were talking about the cost report which is the first step on that long process to payment. Are there hospitals for which there has been no final accounting for the year 1967 yet?

Mr. TIERNEY. There are hospitals for which there has been no final settlement reached, Mr. Congressman. There are relatively few hospitals for which final audits have not been completed. But we sometimes get into a real argument before the hospital accepts the intermediary's report.

Mr. VANDER JAGT. How many have not received the final settlement for the year 1967?

Mr. TIERNEY. I will try to get that for you.

Mr. NAUGHTON. It is approximately 2,000, isn't it?

Mr. TIERNEY. The first accounting year through November of 1969—and I can update this figure for you—the first accounting year there were 6,811 cost reports due. There have been 6,674 reports received. There were 134 in which no audit was necessary, either no medicare business or such a minimal amount that nothing was involved.

Some 6,074 field audits have been started; 5,731 field audits have been completed and 3,890 final settlements have been made. So, 3,890 settlements out of 6,811 institutions reporting.

Mr. VANDER JAGT. So we are taking about a little over half for the year 1967?

Mr. TIERNEY. Yes, sir.

Mr. VANDER JAGT. Almost half have no final settlement for 1967?

Mr. TIERNEY. Yes, sir. Just for the record, Mr. Mayne tells me the figure now is 4,185 as of January 1, 1970, where there has been a settlement.

Mr. VANDER JAGT. But we are still talking about 2,500 who have not received final settlement for the year 1967?

Mr. TIERNEY. Yes.

Mr. VANDER JAGT. You were talking about good administration for a hospital being able to lower the cost that we are so interested in. Is it not difficult to have a good administrative program when you do not know in 1970 yet what you took in in 1967?

Mr. TIERNEY. I am sure it is, Mr. Vander Jagt, but I would state to you again that cost accounting in hospitals is a relatively new thing. One of the problems we have with the program is that the Congress made it clear medicare was to pay the cost for services to medicare beneficiaries and those costs are not to be passed onto the rest of the public and conversely that we not pay the cost of non-medicare beneficiaries.

So we had to develop some pretty detailed cost accounting procedures and cost reporting forms. Many hospitals again were simply not prepared to cope with this. They were not able to produce it and it took a long time to not only delve it out of their books but then audit it.

I think we are talking for the most part, Mr. Congressman, of relatively smaller institutions; the major institutions have been able to and have been settled.

I might also add this: The amount at issue in most of these cases is generally very small. I don't know what figure we have on it but generally the amount of adjustment falls within the range of 5 percent. Generally, not all of it is in dispute. Even if all of that were to go one way or the other, it is still only about 1.5 percent of the hospital income for the year.

Mr. VANDER JAGT. After a large major hospital with good accounting procedures submits its reasonable cost figure, how many audits are necessary between that time and final settlement? Does the intermediary conduct an audit?

Mr. TIERNEY. The intermediary has contracted out with an accounting firm in most instances to conduct an audit. So, first of all, the auditing firm goes in and conducts an audit. However, the intermediary then does make a desk review. Let me put it the other way. First of all, the cost report comes in from the institution.

Mr. VANDER JAGT. Which is the result of the audit the hospital made itself?

Mr. TIERNEY. Yes. The intermediary makes a desk review of that, which is simply checking out the figures to see if they add up, and in an amazing number of cases they do not add up. So the whole thing goes back and it has to be redone. But if it comes in and the desk review looks all right, the intermediary turns it over to the auditing firm and they go out and conduct the audit.

That is then submitted back to the intermediary. If the intermediary is a Blue Cross plan, it then submits the report and audit to the Blue Cross association which doesn't conduct an audit but again takes a

look at the whole situation and determines whether or not there are any policy or legality questions involved which are still open. It is then that the report comes to us.

Now, the only thing I am trying to point out is the tremendous amount of the field audits in going out and establishing what the costs have been, has been accomplished. But the final settlements tend to be delayed by disputes by the hospitals about the findings, even though the issue is often small.

Now, we have done a number of things about this. First of all, we have told intermediaries, once the institution has been audited, to try to satisfy itself by a much more cursory review that the records of the institution are kept in such a manner that they can be relied on.

Mr. VANDER JAGT. Many times each one is using a different accounting procedure and there is little correlation between the three audits done on the same institution in many instances?

Mr. TIERNEY. No; I do not think so. We have reimbursement manuals that spell out precisely what costs are to be in and what costs are to be out and how they are allocated. So everybody is dealing with the same set of rules.

It is conceivable that two accounting firms might have different judgments on a certain situation but they are not going out and using their own ideas on how audits should be conducted.

Mr. VANDER JAGT. But there is no full faith and credit on audits done by recognized accounting firms and the same audit will be done all over again?

Mr. TIERNEY. No, sir, and that is something that has been proposed. Particularly where we have established an institution does keep competent records and competent audits are being made, that we ought to accept a certified cost report from that institution and forget all the auditing.

Our original position was that this whole thing was so new and so complex and different from anything that had happened before that we ought to for educational purposes conduct an audit for every single institution in the country.

Sometimes it looks kind of silly. We spent a lot of money auditing an outfit that we did not pay a lot of money to, but the audit in the first year will have educational effects for many years.

Mr. VANDER JAGT. Are there instances where the money spent on the audit has exceeded the amount paid to the institution?

Mr. TIERNEY. I am not aware of that. I know there has been a substantial ratio to the amount.

Mr. VANDER JAGT. A system that leaves 2,500 hospitals without final settlement for 1 year, 1967, is a system that perhaps could stand some improvement.

I just have one more question, Mr. Chairman.

In this week's issue of U.S. News & World Report they said that the estimated deficit between the cost of part A of medicare and projected income under the present law amounts to a deficit of $131 billion. That is throughout the next 25 years. A deficit of $131 billion in the next 25 years just for part A on the medicare program. Would you agree with that projection?

Mr. TIERNEY. I guess for 25 years it is the numerical result of certain

of our actuaries' calculations and it was mentioned by the chairman of the Senate Finance Committee.

It presupposes a number of things, Mr. Congressman. That is, if everything went on as it is, if there were no increases in the tax base and no changes in the contribution rate allocated to medicare and hospital costs continued to increase, that is what would happen, yes.

Mr. VANDER JAGT. That is my question. If everything goes on the way it is going today, will we in fact accumulate a deficit of $131 billion in the next 25 years, if we don't make a change?

Mr. TIERNEY. Yes, I think it is an accurate statement if nothing changes. As you know, the administrative proposal has provisions in it for change. The tax base—the base upon which taxes are levied—does increase and the rates do go up and it has been recommended to the Congress that the base change and the rate at which they go up be accelerated by making reductions in contributions for retirement benefits which are estimated to be over financed. I think all of those things were contemplated, but, I think the basic statement, if you stopped today and froze everything, 25 years from now we would have that kind of deficit, yes.

Mr. VANDER JAGT. Which is a pretty good incentive for making some kind of changes, isn't it?

Mr. TIERNEY. I would say something would have to happen.

Mr. FOUNTAIN. Not necessarily a raise in the taxes.

Mr. TIERNEY. Not necessarily raising taxes, Mr. Fountain, but I think it is unrealistic to think that the costs of hospital care are going to go down in this country. Every single economic factor would seem to indicate they are going to continue to go up.

If we can get them to go up at a rate no faster than the general economy goes up, we are in good shape. But I really don't think it is realistic to think that through any reimbursement formula or any surveillance or any other operations the hospital costs are going to go down.

This isn't a phenomenon unique to medicare or even to the United States. You have figures going up all over the world. It comes from a variety of reasons. First of all, hospitals are not operations which can be materially changed by automation, by increased productivity. It is still pretty much a person-to-person type of case.

About 65 to 70 percent of hospital costs are tied up in wages and salaries. We have a ratio of somewhere around two and a half to three staff people per patient in a hospital today.

For the most part these aren't the type of people who were working in hospitals 20 years ago when they were largely janitorial and nursing people, they are highly skilled technicians, paramedical personnel.

As the scope of medical science advances, things that are highly desirable, there have been terrific cost impacts. Open heart surgery is a wonderful and dramatic thing, but very costly. People have estimated, for the average open heart operation, $75,000.

As we do more and more of them we are going to have to spend a lot of money. I am not saying every effort shouldn't be made to find ways to curtail the costs, but I don't think it is realistic to think that costs are going to go down.

Mr. FOUNTAIN. If they continue upward, in order to keep the program actuarily sound, taxes likewise will have to go up.

Mr. TIERNEY. Well, there are several alternatives. One is to curtail the benefits, pay less of the bill and not meet the costs as they rise.

Now, the Congress in its consideration of the program at its inception said let's meet the cost of hospital care to the people. I know I am overstating the situation. But I don't think we can anticipate that the costs are going to go down.

As I say, either the benefits are going to go down or the taxes will rise.

Mr. FOUNTAIN. I have a lot of questions in this area, but we are a little ahead of ourselves with these questions. We anticipated getting to the question of costs, but probably not today. For developing the record, we have plans for questions in several subject areas; legislative authority—we have asked questions about that—health and safety standards, use of intermediaries, provider audits, amounts paid providers, statistical analysis and cost comparisons and several others. And I will yield to members of the committee as I conclude laying the foundation in each of these areas.

I might at this point ask Mr. Vander Jagt, do you have any questions in the area of legislative authority, which is the area I have already covered.

Mr. VANDER JAGT. Just one question to determine whether or not it is appropriate to discuss at this time the reasonable cost method——

Mr. FOUNTAIN. We will get into that.

Mr. VANDER JAGT. That will not fall under the change that would come by the legislation?

Mr. NAUGHTON. Yes, it would take legislation to get away from the formula.

Mr. VANDER JAGT. Well, let me ask this one question: Is not one of the factors driving up the cost the factor that you pointed out, that a hospital reimbursed on the basis of reasonable cost, if they do a good job of administration and get the costs down, they get less, so there is very little incentive for cutting the costs and you add to that factor that only 15 percent of the medical bill today is being paid by the consumer.

Where does the incentive come from to get the cost down, and is that something we should think about in terms of legislation?

Mr. TIERNEY. I would have to say to you, sir, as you put it, if through effective administration they reduce their costs, both private and public third party payers pay them less, so that is a kind of anomalous situation.

Mr. VANDER JAGT. Thank you, Mr. Chairman.

Mr. NAUGHTON. I might make one comment before getting into a few questions on legislation. I can certainly agree with your observation that some of the extended care facilities don't have very good records. In reading one of your audit reports about an extended care facility which received a few hundred—at most a few thousand dollars—under the medicare program there was a comment that the records of that facility consisted of a paper bag in which notes on envelopes were placed.

I am sure that was an outstanding example of the lack of adequate records.

Mr. TIERNEY. I would assume that is a pretty good one.

Mr. NAUGHTON. Getting back to the extended care concept, do you think that part of the problem of the fuzziness of this concept is that Congress may have had in mind when the medicare program was enacted that the hospitals would expand or add on extended care facilities and that the treatment of the patients would all be done perhaps in the same building just in a different wing in which less expensive care could be provided?

Mr. TIERNEY. I wasn't around when the legislation was debated but I would tend to agree with you. I think there was an expectation of this—hospitals had talked for many years about having intensive care units, routine care units, and self-care units. There has been a great development of intensive care units but little movement toward the other end of the spectrum.

I think there was a hope that the hospitals would move into the extended care area. This has not developed. Now, we do have, and I can give you a precise number, a number of hospital affiliated or integral part extended care facilities, but they are vastly in the minority.

Mr. NAUGHTON. Doesn't the reasonable cost reimbursement formula make more sense in thinking of hospitals which are mostly community institutions run on a nonprofit basis as compared to nursing homes which are historically proprietary institutions?

Mr. TIERNEY. I suppose it does. As you know, Mr. Naughton, the Congress wrote into the legislation for proprietary institutions a return on net equity capital which was at the rate of 1½ times the average of the rates of interest paid on fund securities. This, as you know, is the profit they make on services provided to medicare beneficiaries. The nursing home field feels this is entirely inadequate and it is constantly searching for more. I would think basically I have to agree with you, it makes more sense to reimburse a nonprofit institution on a cost basis than it does a proprietary operation in which there is an investment on which it is seeking a return.

Mr. NAUGHTON. Certainly even in a nursing home, there is nothing wrong with people being in a business for profit if they provide good service. You can't expect them to be happy with working on a cost basis, whereas in the community hospitals most of them would be happy if all of their costs were met.

Mr. TIERNEY. If every one of their costs were met this would be a nice operation.

Mr. NAUGHTON. There has been no recommendation for clarification of the extended care concept or a change in the concept?

Mr. TIERNEY. Legislatively?

Mr. NAUGHTON. Yes.

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. The third item you mentioned was the lack of authority to attach funds and place liens on property of those who may not have filed cost reports or who may have been overpaid. There has been no recommendation on that, has there?

Mr. TIERNEY. Yes, sir. As you know, you must first submit proposed legislation to the Bureau of Budget for clearance before it can be presented. We have a recommendation in that regard at the present time.

Mr. NAUGHTON. But it hasn't gotten to the Congress yet?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. Aren't there some agencies in the Government, the Justice Department or the General Accounting Office that presently do have sufficient legal authority if it is needed to place such liens?

Mr. TIERNEY. I don't believe the General Accounting Office has the jurisdiction to place liens. I think the Justice Department has, but through a writ obtained from the court. The Internal Revenue Service can do it independently.

Mr. NAUGHTON. Has any attempt been made administratively to work out arrangements through the Justice Department whereby social security could do the paper work and transfer documents to the Justice Department for filing on an accelerated basis?

Mr. TIERNEY. That is what we do. We follow the Federal Claims Collection Act which provides that the agency will make every effort it can to effect collection. If it can't do it, it refers it to the General Accounting Office and if they can't effectively not only set up a collection schedule but make a settlement, which is another area where we don't have any significant authority, then they turn it over to the Justice Department.

We have followed this in every instance in which that kind of action has been taken.

Mr. NAUGHTON. We will have further questions on the subject of collection of overpayments on Thursday, I am sure.

The fourth item on the list here is reasonable costs. There has been no recommendation to the Congress, has there, that that formula be changed?

Mr. TIERNEY. No, there hasn't been a recommendation other than the recommendation which is presently pending to allow the Secretary to develop techniques for doing so.

Mr. NAUGHTON. For doing what?

Mr. TIERNEY. For departing from the reasonable cost retroactive reimbursement approach.

Mr. NAUGHTON. This would be on an experimental basis and would not affect the majority of the providers?

Mr. TIERNEY. We would hope it would be a short experimental period, Mr. Naughton. It is well enough to say let's get off of retroactive cost adjustment and on to some prospective rate. But that in itself has a myriad of problems. In the first place I am sure no one would stand for the rates unless they were pretty well correlated to costs.

So you have to start with a cost picture or assume the present one is correct.

Who does this negotiating? You have 7,000 hospitals and 4,000 ECFs and all the other people I told you about. There is a question there. Do you really negotiate a rate, go out and sit down and bargain a rate or do you think of this thing in terms of a public utility concept in which you enunciate principles that would be built into a rate and out of applying the mathematics of a given institution to that set of principles a rate emerges?

I think these are the things we have to have answers to before we can make a recommendation to Congress, to get on a retroactive determination basis away from paying people their costs and to begin negotiating rates of payments on a prospective basis.

Mr. NAUGHTON. Well, we have two questions involved here. One is: Should the reasonable cost formula be changed to a negotiated basis? That is one problem and you indicated you are studying it.

The second question is how the word "reasonable" in the present law should be interpreted.

Is it your belief that that word is to be ignored and you are to pay all costs no matter how high they are?

Mr. TIERNEY. No, I wouldn't agree with that. On the other hand, the word itself is extremely difficult to define. The Congress said you pay the appropriate share of the incurred costs of each institution and you take into account such things as the rate of occupancy, the staffing level and other things.

One problem is where you have an institution with a low level of occupancy. The costs have been incurred. They have spent the money. They are available to take care of more people but they only have been 50 percent occupied.

That gets down to the question: Is the resulting cost reasonable or not? Do you compare them with an institution that is 50 percent occupied or 95 percent occupied?

If they have a comparable scope of service, they are going to be way out of line with the one that is 95 percent occupied. What we have done is this: There are certain fixed costs in an institution, as you well know—depreciation, heat, light, and maintenance. The overwhelming remaining portion of it is staffing costs.

We have instructed intermediaries that if the institution has been providing staff beyond the needs of medicare beneficiaries, this is unreasonable. We have instructed them that if an institution is departing from prudent purchasing procedures, if it is paying more for drugs than drugs cost at the drug store, this is unreasonable. But you can develop quite high costs, Mr. Naughton, on a given day with a new institution opening for example.

You have a tremendous amount of fixed cost there and if they only get 10 patients in the first day the cost per day of those 10 patients is very high.

Now, over a period of time, if there is a community need for the institution, those costs will be obviously diluted as occupancy increases. I don't know if I am being responsive to your question, but I don't think reasonable means whatever they incurred.

On the other hand, I think it doesn't necessarily mean that simply because it is higher than another institution it is unreasonable.

Mr. NAUGHTON. Well, do you feel that because of mandatory provisions of the law or the legislative history that you have been required to pay costs which you feel are exorbitant or unnecessary or unjustified that you would not have paid it had it not been for unreasonable provisions of the law?

Do you feel you have sufficient freedom to work out what you consider to be reasonable costs and do the best you can under the existing formula?

Mr. TIERNEY. I would have to say this. If the law didn't say that the medicare program will cover the reasonable costs of a given institution, no matter how much they may vary from others and so forth, then we would have greater freedom to go in and say to an outfit, "Look, we

will negotiate a rate with you, we are not going to pay you your costs because we think they are out of line."

We can't do that under the present situation, but that doesn't mean we have to recognize their costs as being reasonable. So I think it is a more basic issue than whether reasonable cost is less than full cost in deciding as to whether or not the present law unduly restricts us.

The answer to your question is that the present law specifies payment will be made on a cost basis. I think what we are tending to believe and would like to be able to prove is that that isn't the best way to reimburse that we might be better off with a target rate or negotiated rate or budget rate.

Mr. NAUGHTON. But you never recommended to the Congress that any changes be made in the wording of the law?

Mr. TIERNEY. No, sir.

Mr. FOUNTAIN. Have you given consideration to the use of the term reasonable charge rather than reasonable cost, which would necessitate probably some negotiation?

Mr. TIERNEY. On the part B side of the picture it is specified that payment, other than to providers, be on the basis of the reasonable charge. So that is what we do there, Mr. Chairman. What I am talking about here when we call it a target rate is in essence an agreed-upon charge to be paid but determined so that you know before the beginning of the year what you are going to pay *x* hospital, in the absence of unusual circumstances. I suppose you would always have the provision, you know, if the total employee force goes out on strike and the hospital is forced to give a 20 percent pay increase, you have to give it recognition. But nevertheless that is what you are going to pay.

Mr. FOUNTAIN. If I were going to put up a nursing home, unless I were a person like some I know who like to do that sort of thing and just want to do it to make a living for themselves but don't want to make a profit, I don't know what incentive I would have to build a nursing home if I had to get part of the payment now and get the other part in a year or 2 years and not know whether or not you are going to make demands for refunds on the basis of an audit.

It seems to me you have to work out some sort of system where you know in advance what you are going to pay and the man knows what he is going to receive. Otherwise there is no telling where the cost of this program is going to go.

Mr. TIERNEY. I agree with you only one further thought. That is I am not sure approaching reimbursement through charges, even if agreed upon, is going to reduce costs. There is no organization that is going to agree to a charge which they don't think is going to cover their costs. They are going to look for their costs plus whatever they feel they need above that. It would give a greater prospective control, it would eliminate some of the complications and expenses of retroactive auditing and adjustment.

But I don't think any organization is going to negotiate a rate with you that doesn't cover its costs.

Mr. FOUNTAIN. We just went through an experience in North Carolina with nursing homes. I guess you heard something about that, we won't get into it now, but nursing homes have a problem and some

of them don't know how long they are going to operate. They served an ultimatum to a lot of patients that they couldn't afford to keep them because they weren't getting paid enough.

I am sure many of these were welfare cases on medicaid. But they could get private patients who could pay the rate. We just had quite a problem.

I had one lady call me and said her mother is 90-some-odd years of age and she had to get out of the home the next day.

We had some nursing home people say they are not going to put anybody out but they are going to have to close down.

Like Congressman Vander Jagt, a lot of the questions I would like to ask are based on observations on the local scene.

Mr. NAUGHTON. The law requires, does it not, that the medicare program is to pay the reasonable cost of medicare patients and not to pay the costs attributable to other patients and vice versa?

Mr. TIERNEY. That is right.

Mr. NAUGHTON. Is it true that the medicare program in some instances has paid a portion of the costs of operating the maternity wards of some hospitals?

Mr. TIERNEY. Mr. Naughton, as you know there are two basic approaches to how we determine the allocation of hospital's total cost to medicare. One is the so-called departmental cost accounting approach.

Mr. NAUGHTON. Would it be possible to say yes or no before you start?

Mr. TIERNEY. No, I don't think it would. Because I am not sure it has happened. Under the departmental approach, this requires a great deal of accounting for all and medicare charges by department, and we have some accountants who are more articulate about it than I. But the routine services are broken up into one department and all the ancillary services, such as X-ray, lab, operating room, surgery and the rest, are broken out by department and the cost and charges of each department ascertained.

Then to find out what portion of those costs are medicare and which are not you apply the charges made to medicare to the total charges of that department and you apply that ratio to the cost of each department and out of this comes the medicare allocation of costs.

Mr. NAUGHTON. Are there some accountants who claim you are picking up a portion of the cost of the maternity wards?

Mr. TIERNEY. Yes, this is the way they say we pick up some of the costs. Under the combination method which is another way of estimating the costs of medical patients, you break out the routine costs and lump all of the costs of the ancillaries, no matter what they are—the operating room, pharmacy, whatever—and you apply then the ratio of the charges for all ancillary services furnished to medicare patients to the charges for all ancillary services furnished to all patients to the costs of these ancillary services.

Obviously in the maternity room, as far as we know we have had no maternity cases, so there are no charges for services to medicare beneficiaries. This affects the charges-to-charges ratio used to find the medicare portion of cost. But it is alleged that charges for maternity services generally do not fully cover the cost of some maternity

services in some institutions. So to the extent that is true, that there is a cost there for which no medicare services are furnished and you applied the charges-to-charges ratio to the ancillary costs, some portion of that cost might become a part of medicare reimbursement.

Now, in a given institution that is a possibility based entirely on whether or not that institution's relationship of charges to cost is the same in the obstetrics department as the average of all departments.

The combination method was devised, and is still made available to hospitals, largely because the basic problem was that many hospitals found it impossible to maintain all of the charge data needed to determine cost on a department by department basis.

I wish you could see the amount of work involved in this sort of thing—breaking down charges by department for services to medicare beneficiaries as well as for all patients down through every type of department. Many of the hospitals weren't in a position to do that. But that is the method and that is the basis for the charge that I am sure you heard, that by employing that method it is possible medicare may be paying a portion of delivery room costs.

Mr. NAUGHTON. In other words, any institution using the combination method, where the costs of operating the maternity ward exceeded the charge to the persons using the maternity ward, would in effect be getting a part of that cost placed on the bills of the medicare patients or the reimbursement for medicare.

Mr. TIERNEY. Not on the bills but in the cost of ancillary services and only if the ancillary services that medicare patients use had in effect a higher markup than the total average cost of ancillary services including delivery room costs in the institution. I am not trying to evade your question but there are cost determination procedures which are, at best, inexact. It may be that in the hospital the medicare people are getting a lot of drug care but the charges aren't appropriately related to the cost of the drugs; that is, the markup is less than the average markup. Therefore medicare would be getting a bargain.

Mr. FOUNTAIN. Well, we are going to have to shut off here. I wish we could continue in the morning and continue from day to day, but our function here is such that we have to do this when we can.

So the committee will stand recessed until 10 a.m. Thursday morning, same place.

(Whereupon, at 12:15 p.m., the committee was recessed, to reconvene at 10 a.m., Thursday, 19 February 1970.)

ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(Part 1—Medicare Program)

THURSDAY, FEBRUARY 19, 1970

HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10:15 a.m. in room 2203, Rayburn House Office Building, the Honorable L. H. Fountain, chairman of the subcommittee, presiding.

Present: Representatives L. H. Fountain, John C. Culver, Florence P. Dwyer, and Clarence J. Brown.

Staff members present: James R. Naughton, counsel; D. C. Goldberg, professional staff member; and Thomas H. Saunders, minority staff.

Mr. FOUNTAIN. The committee will come to order.

Mr. Tierney, yesterday I believe Mr. Naughton asked you if the medicare program in some instances has paid a portion of the cost of operating the maternity wards in some hospitals. And I believe you said you could not give a yes or no answer without comment and you discussed this.

Have you had an opportunity to check into that since yesterday?

FURTHER STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, SOCIAL SECURITY ADMINISTRATION, BUREAU OF HEALTH INSURANCE; ACCOMPANIED BY HENRY HEHIR, CHIEF, PROGRAM INTEGRITY STAFF; MANUEL LEVINE, CHIEF, DETERMINATIONS REVIEW STAFF; MORRIS LEVY, ASSISTANT BUREAU DIRECTOR, DIVISION OF STATE OPERATIONS; ROBERT MAYNE, ASSISTANT BUREAU DIRECTOR, DIVISION OF INTERMEDIARY OPERATIONS; MORRIS OLDER, DEPUTY ASSISTANT BUREAU DIRECTOR, DIVISION OF REIMBURSEMENT; JAMES RILEY, CHIEF, COST ANALYSIS SECTION; IRWIN WOLKSTEIN, ASSISTANT BUREAU DIRECTOR, DIVISION OF POLICY AND STANDARDS; AND W. N. HENRY, ASSISTANT DIRECTOR, AUDIT AGENCY

Mr. TIERNEY. Yes, I have had a chance to review the transcript, Mr. Chairman——

Mr. FOUNTAIN. Do you have anything further to add in response to that question?

Mr. TIERNEY. I think what I intended to respond to Mr. Naughton's question was that there are currently two acceptable mechanisms which we have outlined for institutions to report their costs and for an ultimate determination of medicare reimbursement.

One of them as you will recall, is what we termed the departmental method; the other is the so-called combination method.

When the program started, Mr. Chairman, we had four methods, because it was virtually impossible for institutions to originally do even the combination method. We had what we called a gross RCC method. That was simply taking the ratio of total medicare charges to total charges made by an institution and applying that to costs across the board. We eliminated that because it is too inexact, even though in the beginning it was all some institutions could do.

We also had what we called an estimated percentage approach to the combination method. That was a method under which you tried to estimate the allocation of costs to various departments. Under the approach, the intermediary estimated, because cost funding could not be employed, the costs of routine and ancillary services, and then the combination method approach was followed.

We have then left the two mechanisms, one in which there is full departmental costing and full departmental charge ratios established.

That, I would have to say, Mr. Chairman, is perhaps the most exact method, but is nevertheless not fully determinative of actual costs. The combination method, as I explained it on Tuesday, does take the aggregate ancillary service charges to medicare patients and apply it to the aggregate ancillary charges to all patients and then applies that ratio against the aggregate costs for all ancillary services.

Now I agreed with Mr. Naughton that it is possible under that situation that even though no charges for maternity care were made against medicare patients (so the ratio for that service is zero) that if the costs of maternity care in a given institution exceed the charges that are made for that service, then some portion of that cost comes over into the total cost against which the ratio is then applied. And I admit that that is a possibility.

The point I was trying to make with Mr. Naughton is that that does not necessarily mean that we are overpaying a hospital its costs. When this program started, Mr. Chairman, the hospitals of the Nation based on studies which they had made took a very strong position that the costs of the aged, not only the routine daily nursing costs, but just the costs of taking care of older people, exceeded those of younger patients.

They gave an example of an 85-year-old woman taken down to the X-ray department for a GI series. There is a lot more time, a lot more cost involved in doing it for her than there is a young 25-year-old buck.

We don't allow any differential in charges. Our rules require that medicare people be charged the same as anybody else. So that they claimed in virtually every department we were underpaying. Specifically, of course, in the routine daily nursing service, where old people may be suffering from incontinency, or need spoon feeding, or something else, that the actual cost of rendering routine nursing service to them was excessive.

So in the original reimbursement formula that was ultimately negotiated between the Department and the hospitals of the Nation there was a so-called 2 percent factor, which was applied to an institution's total operating costs; you took 2 percent and added it on and the aggregate medicare portion was to be reimbursed.

That fell into a lot of criticism. People looked upon it as a cost plus. It was a 2 percent factor applied across the board, whether it was a big or little hospital, a lot of medicare, no medicare, teaching, nonteaching, and it was not related specifically to the care of the patient. It was just 2 percent. If food went up, whatever went up, 2 percent went up. So that provision was eliminated by an announcement of the Secretary in April of last year and became effective July 1.

At that time the Secretary also directed us to reopen the whole question of reimbursement with the institutional providers of the Nation and to see if there weren't more exact and at the same time simpler mechanisms by which we could reimburse hospitals.

We have been actively negotiating ever since. We are hopefully going to come up with some of the solutions that I spoke to Mr. Vander Jagt and other members of the committee on Tuesday. That is a long-winded reply to your question, Mr. Chairman.

The answer is, as I have said, that in a given institution, depending on the relationship of charge to cost of the maternity department, it is possible some of the costs of the maternity department ultimately are included in medicare reimbursement under the combination method, but I would still argue, or not argue, but want you to fully understand that that does not necessarily mean that we are overpaying the hospitals' costs. Because in many other areas it is their assertion we are underpaying them.

Mr. FOUNTAIN. This is somewhat aside from the basic question.

You commented upon the alleged cost of looking after the elderly as compared with the young. I think obviously there may be merit to that contention.

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. I think there is also merit to the contention that automatically adding 2 percent everywhere is not a proper way to do it either. So obviously you are wise in trying to find a new solution to it.

Mr. Naughton, do you have some information on delivery room costs?

Mr. NAUGHTON. I have some questions and additional information for the record.

Mr. Tierney, the law requires that the costs of medicare patients be allocated to medicare patients, and that the medicare program not pay the costs of non-medicare patients and vice versa.

Mr. TIERNEY. Yes, sir

Mr. NAUGHTON. That is very clear, is it not?

Mr. TIERNEY. Very clear.

Mr. NAUGHTON. As a matter of fact, in a letter you sent me on August 8, on another matter, you quoted a portion of an opinion of the office of General Counsel talking about what the law requires, and it was stated there that—

One mandate emerges clearly, that there be as precise a differentiation as possible between the cost of service to the beneficiaries of this insurance system

and the cost of the services to other patients. Congress plainly intends that this program should pay the full cost, but should pay no more than the cost of the services provided to the program's beneficiaries.

Now you cannot of course authorize by regulation or policies of the administrative agency something the Congress has prohibited, can you?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. There is no question, is there, that the combination method does result in some costs of the delivery rooms being included in the amounts reimbursed partially by medicare patients?

Mr. TIERNEY. Mr. Naughton, I think I have answered that question. There is no question but that in some cases that could happen. But the Congress also enacted into the law that the Secretary should use his best judgment and should estimate to the best extent possible that this provision of the law be carried out, that the costs of medicare beneficiaries not be borne by other people, and vice versa.

Now this method is, at best, an effort to do that. I think what the thrust of your question is, you are picking out one service a hospital renders, which medicare beneficiaries in most cases do not use, although in some instances——

Mr. NAUGHTON. Do you know of any cases where the delivery room is used for that purpose by a medicare beneficiary?

Mr. TIERNEY. Yes, I know of some cases where there obviously isn't a delivery, but the Joint Commission on Accreditation of Hospital Standards allows the use of the whole maternity service facility for gynecological patients, so some older people do wind up in that department. But I think that is begging the question.

Mr. NAUGHTON. Yes. It is a very minor factor, if at all.

Mr. TIERNEY. As I was pointing out the Secretary is supposed to use whatever mechanisms he can to get down to that fine exquisite ending where everything paid for is reasonably precise. And he is allowed the authority to estimate what is the actual situation.

Mr. FOUNTAIN. Pardon me. I might say for the benefit of Mr. Brown and Mrs. Dwyer that just before you came in we were pursuing some questions asked previously concerning the extent to which maternity costs might be involved in the cost reimbursed by medicare and Mr. Naughton is asking some questions along these lines.

Mr. BROWN. Somebody else's maternity costs, you mean?

Mr. FOUNTAIN. Yes.

Proceed, Mr. Tierney.

Mr. TIERNEY. If you were to ask the further question, is the full departmental method a more accurate method, I suppose I would have to agree with you, that to the extent that it attempts, again through some arbitrary rules, to totally identify the actual charge of each department against its actual cost of each department, it results in perhaps a closer approximation of actual costs.

If you talk to the hospital people of the Nation, Mr. Naughton, and I am sure perhaps you, Mr. Chairman, have been exposed to this, they claim that we are grossly underpaying their costs and not meeting their costs under our present formulas. And that is the effort, therefore, that we are carrying on at this time to negotiate a mutually satisfactory arrangement which will to the fullest extent possible, without getting into such an elaborate accounting that it would really

be kind of an overkill situation, to reach a jointly acceptable mechanism.

In the meantime these mechanisms have gone on. I think we might argue endlessly, Mr. Naughton, as to whether or not it does do an effective job in the overall, of effectively trying to determine the actual cost of the medicare beneficiaries.

You obviously feel that since there might be some elements of a delivery room cost in the situation, we are overpaying the hospital. I could not agree with that.

Mr. NAUGHTON. The matter of overpayment is not involved in this particular question. Congress has said that the medicare program shall pick up the costs of the medicare patients, it shall not pay the costs of non-medicare patients.

Now, granted there are serious problems involved in trying to allocate those costs properly. You may have to make estimates at times, you may have to make judgments. But it seems to me that a judgment that the medicare program should pay part of the costs of the delivery room is unsupported by any factual evidence that I can see.

Mr. TIERNEY. I don't think anybody has made that decision, Mr. Naughton. The decision was that while there might be some cost there that was included, as I pointed out, there are costs in other areas which are not included, and therefore this is not an effort to include delivery room services. It is an effort to break hospital costs into two broad categories: First, the daily routine service charge, room, board, meals, and routine nursing care.

The rest is all of the ancillary services of the hospital combined—X-ray, lab, surgery, everything else. Now when you combine all of those costs, and then combine all of the charges, and there being no charges made to medicare people for delivery room services, you cannot say black or white, yes or no. Some of those costs fall into medicare. It is simply an effort to allocate costs on that broad basis.

Mr. NAUGHTON. Under the combination method all of the costs of ancillary services are put into a pool; are they not?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Including the cost of the delivery room?

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. All of the costs are figured up and divided proportionately to the charges?

Mr. TIERNEY. You figure the ratio of medicare charges to total charges, there being generally no medicare charges for delivery room charges.

Mr. NAUGHTON. So if medicare patients were charged half of the charges of the hospital, they would pay half of the costs of the delivery room under the combination method for ancillary services?

Mr. TIERNEY. No; I don't think they would.

Mr. NAUGHTON. If half of all ancillary charges——

Mr. TIERNEY. There being no charges for the delivery room.

Mr. NAUGHTON. Under the combination method, if medicare patients were charged 50 percent of the total ancillary charges, they would pay 50 percent of the pool of costs for all ancillary services; would they not?

Mr. TIERNEY. Yes; they would pay their proportionate ratio of charges to cost.

Mr. NAUGHTON. Which would include a share of the costs of the delivery room.

Mr. TIERNEY. I want to make very sure what you are saying, Mr. Naughton. Assuming the medicare patients have half of the ancillary service charges, then they would be paying half of the costs.

Furthermore, it breaks down to this point: How closely related are the charges for delivery room service to the cost of delivery room service? If they are actually related, if the charges cover the costs, and this relationship is the same as that of other ancillary services to be apportioned to medicare, then there is no portion of the costs to be apportioned to medicare.

Mr. NAUGHTON. I would grant the formula would work out at no disadvantage to either party if the charges were exactly the amount of costs.

Mr. TIERNEY. Right.

Mr. NAUGHTON. In most cases that is not true, is it?

Mr. TIERNEY. I don't know whether in most cases it is true. I think traditionally it used to be true. For at least 10 years, the American Hospital Association has been making a concerted effort to relate the charges of every service in hospitals to the costs of those services. And I think a great deal of progress has been made.

Mr. NAUGHTON. In view of the limitations on time, suppose we get away from the technicalities of the formula and talk about what some people have said about it.

Mr. BROWN. May I interrupt for a minute. Mr. Naughton, are you using a precise term when you are talking about the various systems of allocation? Whose term is that? Is it yours or the Government's?

Mr. TIERNEY. It is our term, Mr. Brown. We have developed in the course of these hearings that there are two basic reimbursement mechanisms, which are available to institutions in an effort to ascertain the costs of medicare patients. One we call the departmental method; the other we call the combination method. So when we speak of this combination method, that is a terminology we have applied to a medicare reimbursement procedure.

Mr. BROWN. I have listened to this since I have come into the room and I am still not sure I understand the answer to the question that I hear Mr. Naughton trying to ask. Is a maternity ward allocated to the cost of a medicare patient in a hospital? I think that is a very simple question.

Mr. TIERNEY. I am answering the question, Mr. Brown, that under the combination method some portions of the delivery room costs, since we do not break down all of the ancillary services of a hospital, X-ray, laboratory, surgery, delivery room, everything else that is there department by department, but rather lump the costs of those ancillary services and then apply the ratio of medicare charges of these services to total charges for these services it is possible that even though there are no charges for delivery room services made to medicare and, therefore, the ratio of charge to charge is lowered, that if the charges made to nonmedicare patients for delivery room services do not cover the full cost of delivery room services, then some portion of those costs might appear in the total allocation of costs to medicare.

Mr. BROWN. Mr. Chairman, I do not want to——

Mr. FOUNTAIN. I think, Mr. Brown, if we could get Mr. Naughton

to start giving any factual situations he may have in mind, it might help get these questions answered.

Mr. NAUGHTON. We had some previous testimony on the formula.

Mr. BROWN. All right.

Mr. FOUNTAIN. He testified on this yesterday. We are trying to clarify it now.

Mr. NAUGHTON. Is it true in the fall of 1967 the New York Blue Cross plan questioned the legality of the combination method because it included the costs for private rooms, and to some extent, delivery room costs in the pool to be reimbursed by medicare?

Mr. TIERNEY. Yes; I think Mr. Ingram in New York raised a question as to whether or not the combination method should be made totally available as a mechanism for reimbursement.

Mr. NAUGHTON. Is it true that in September 1967 your own Office of General Counsel stated the inclusion of delivery room costs and private room costs to be reimbursed by medicare was not legal in its opinion?

Mr. TIERNEY. I think if you are trying to say, Mr. Naughton, that a direct recognition of delivery room costs would not be appropriate under medicare, the answer is "Yes," and the General Counsel did say that.

I do not think the General Counsel ever, however, took the position that this reimbursement mechanism was a totally inappropriate one. You have so many variables, Mr. Naughton. For example, cataract surgery is virtually a medicare benefit these days. There are relatively few people under 65 with cataracts. So we are covering most of the cataracts in the Nation.

Now, there is no differential in the surgery charge between medicare patients and nomedicare patients, even though we have this high proportion of medicare. So there you have an instance of where we are probably not paying enough of the surgical costs.

So it is at best, sir, an effort to make an appropriate allocation between the costs the hospitals are incurring for medicare patients and nonmedicare. And I think the fact that one element so distinctly stands out as being a service that medicare patients would not use, if you eliminate that one, and do not take any provision for the other things that they do use and we do not allow any differentials in, we wind up, in the overall, underpaying hospitals.

Now, I think what the Congress said is not that you are going to pay every little single thing down to the end on every single patient; what it said is you will make an effort to pay this institution the costs it has incurred in taking care of medicare beneficiaries. That is what we think this method results in.

Mr. NAUGHTON. Now, the Congress said two things, Mr. Tierney: It said you shall pay all costs, No. 1; and it said, No. 2, you shall pay only those costs which are incurred or caused by medicare patients.

I think you are suggesting in effect that two wrongs will make a right here, that if we have not paid all costs in other areas, by putting in some of the delivery room costs, we can make it up to the hospitals.

Mr. TIERNEY. No, I am not suggesting that Mr. Naughton. I am suggesting that after you have gone through all of the accounting mechanisms in the world there still has to be some element of estimating, some element of judgment as to whether or not you are paying a

given institution the total costs it has incurred in providing care to medicare beneficiaries.

We think that the combination method, while not as precise perhaps as the full departmental, but nevertheless the only thing that many hospitals are still able to accomplish, reasonably accomplishes that intent.

Mr. NAUGHTON. Who decides whether the combination method or the departmental method is to be used?

Mr. TIERNEY. You mean who makes the decision?

Mr. NAUGHTON. Who makes that determination?

Mr. TIERNEY. The hospital.

Mr. NAUGHTON. Do you know of instances in which hospitals have figured it both ways and naturally picked the one which would get them the most reimbursement?

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. Have you any idea of how much is involved in those amounts?

Mr. FOUNTAIN. If they are smart operators, I would imagine they have all done that.

Mr. NAUGHTON. Not quite all.

Mr. TIERNEY. I do not have a dollar figure on what the differential might be.

Mr. NAUGHTON. Private room costs are also involved in the distinction between these two formulas, are they not, in that in the departmental method, as I understand it, the costs of routine services, the nursing service, board and room, are allocated on the basis of charges, so that the charges for private rooms being higher, the patients in the private rooms would pay a higher share of the costs, the patients in wards, the charges being lower, would pick up a smaller share of the costs? But in the combination method, all of the routine costs are totaled, and the total number of patient days are divided into that to figure out an average per diem and then in order to compute the medicare reimbursement, you simply take the average per diem and multiply it by the number of medicare patient days.

Mr. TIERNEY. You are right, Mr. Naughton. You take, of course, not only the private room costs, but the semiprivate room costs, and the ward costs, so that you have a cross section of all of the costs, some being higher, some lower.

Mr. NAUGHTON. Yes; and if you use the departmental method and allocate costs in the same ratio as charges, then this will automatically crank in a factor to take up the higher charges for the private rooms and the lower charges for the wards?

Mr. TIERNEY. It is not necessarily more accurate, Mr. Naughton. You have to assume again that the charges being made are really related to the costs. Quite the opposite is true. I do not think that the charges are directly related, I mean the charges directly related to the costs of a room. A very high percentage of the costs of hospital care are centered around what we term routine nursing services. Housekeeping, administration, every element of overhead is largely centered around the room charge.

Hospitals have for long periods of years not had in the room charge probably as high a charge as they should have had to cover the actual costs involved.

So I do not think that I could agree with you that by using the departmental method you come out with an absolutely more specific mechanism of determining the actual cost of those services than you do by the combination method.

Mr. BROWN. Mr. Chairman, may I interrupt at this point again?

Mr. FOUNTAIN. Yes.

Mr. BROWN. I am sorry. I do not understand that statement at all. It seems to me under the departmental method medicare would not have any charge against the maternity ward, would it?

Mr. TIERNEY. Under the departmental method there would be no charge; no, sir. Under the combination method there is no charge. So that there is no ratio of charge-to-charge applied to the maternity costs.

Mr. BROWN. Now, let me say it again, because maybe one of us does not understand accounting. There would be no charge against the maternity ward under the departmental system because you do not have any medicare patients using the maternity ward?

Mr. TIERNEY. Under either system there would be no charge.

Mr. BROWN. Apparently I do not understand the combination system. As I understood that system, you put all of the charges for all of the departments together and take the percentage of charge that medicare is to the whole hospital cost, and everything is charged out through all of the departments. On that basis, medicare would be charged with the maternity ward?

Mr. TIERNEY. There would be no charges——

Mr. BROWN. I am saying it backwards. The maternity ward costs would be charged to medicare patients?

Mr. TIERNEY. Mr. Brown, again the whole mechanism is what we call the RCCAC. The ratio of charges to charges applied to cost. What we tried to do is take the hospital charges to medicare, determine the ratio of those charges to total charges to all patients and then apply that ratio to total costs.

In either the departmental method or the combination method, there would be no charges for delivery room services in the medicare charge. So that, as I said to Mr. Naughton——

Mr. BROWN. Let me put it in as simple terms as I know how. There would be no payment by medicare patients for the cost of maintaining a maternity ward under the departmental system; is that right?

Mr. TIERNEY. Well, you know I can never say an absolute no. But it would be a more exact definition of medicare liability or medicare assuming a portion of those costs.

Now, if the charges in a given institution for delivery room services cover the cost of delivery room services to the same extent that other ancillary charges cover the costs of ancillary services, then the result is exactly the same under the combination method. The point Mr. Naughton is making is if you assume that the charges for delivery room services do not cover the full costs of the services, then some portion of those costs may ultimately fall down into the total operating ancillary costs of the hospital against which the ultimate ratio of medicare charges would be applied.

Mr. BROWN. I understand that. But that seems to me to be a commentary on the quality of cost accounting done by the hospital and not on whether you use the combination or full departmental method.

I run a small business, not as big as most hospitals, even small hospitals. You can certainly separate out your administrative costs and your other costs, and assign them to departments as every small business does and wind up without medicare patients having to pay the cost of the maternity ward or the administration of that maternity ward or the heat, light, and power for that ward or anything else, I would think, if you have any kind of sensible cost system at all.

Mr. TIERNEY. As I said, Mr. Brown, in the beginning, when medicare started there was a rather appalling dearth of sensible cost accounting systems in the hospitals of the Nation. They had not been required to make this distinction between costs of various classifications and segments of people.

Even Blue Cross plans that paid on a cost basis, they paid costs whether you were an infant or 90 years old, it was costs. Most of this was paid on an average-per-diem basis.

Medicare represents the first effort in the history of third-party payment in this country to delineate, define, specific costs for an individual segment of a hospital population which started out of necessity with some hospitals using what we called a gross RCC method, because they had no other way of approaching the problem.

We simply took the gross ratio of medicare charges to total charges and applied it to costs. There was no other way to reimburse hospitals in the beginning.

That we have eliminated. We then had an estimated method that we eliminated.

It really is a question of how fast can you develop the capacity in the system of the Nation to get down to a precise type of cost accounting that you or I might find desirable?

The other question is how much of this is worth doing in terms of honest dollars?

We are accused by the hospital field particularly of overauditing, of being guilty of an overkill in cost accounting. Their greatest plea is for a simplified method of approaching this thing.

It is a difficult problem for them and I think in some instances perhaps we are trying to be too specific.

Accountants are in great demand, young accountants coming out of school these days can get a job just about anywhere. And, frankly, there are many hospitals, particularly smaller hospitals across the whole face of the Nation—and the vast majority of hospitals in this Nation are smaller hospitals—that simply haven't developed that kind of accounting capacity.

Mr. BROWN. It sems to me that in view of the list of horrible examples that seem to be available in this field, I hope some of those young accountants find jobs in the hospital field.

Mr. NAUGHTON. Mr. Tierney, you talk about the problems of accounting systems.

You didn't restrict the use of the combination system to those hospitals which did not have adequate accounting systems, in your judgment, to use the departmental method; did you?

Mr. TIERNEY. No, we didn't, Mr. Naughton.

Mr. NAUGHTON. Now, in 1967, after the General Counsel's Office questioned the legality of inclusion of costs of private rooms and delivery costs through the use of the combination method, is it true

that a proposed intermediary letter was prepared, which would have stopped this, but was not sent out?

Mr. TIERNEY. I don't think that was in 1967, Mr. Naughton.

Mr. NAUGHTON. The questioning was in 1967.

The letter would have been in 1968, I assume.

Mr. TIERNEY. No; I think a letter was prepared in 1969, which suggested that at this stage of the game we should depart from this and require and force all hospitals to go on a full departmental accounting basis. It was at this point in time that the Secretary reached a decision to eliminate this 2-percent factor which was supposed to be the factor which offset our underpayment of what hospitals alleged to be their total costs, and instructed us to undertake a total reevaluation of the reimbursements mechanism which we are doing.

At that time the decision was made, therefore, not to suspend this mechanism of reimbursement, but to go ahead and try to work out a whole new way of reimbursement.

Mr. NAUGHTON. Who made this decision?

Mr. TIERNEY. I made the decision.

It had the approval of my superiors.

Mr. NAUGHTON. Is it true that the Blue Cross Association in Chicago, after the 1967 letter by your General Counsel questioning the legality of this, recommended that its plans continue to use this method, which includes the costs of delivery rooms?

Mr. TIERNEY. Not only the Blue Cross Association of Chicago, but the hospital systems of the Nation and all other intermediaries involved, as well as members of my staff were very much concerned that the elimination of this method under the existing circumstances, would result in a substantial underpayment of hospital costs in the country.

Until we found some other and more perfect mechanisms that could be employed, that that would be the result and they made a strong, took a very strong position in this regard.

Mr. NAUGHTON. Are you familiar with a summary report on audits of administrative costs incurred and benefits paid by fiscal intermediaries, which was prepared by the HEW audit agency? The date of the letter of transmittal is February 5, 1970?

Mr. TIERNEY. I am.

Mr. NAUGHTON. Are you familiar with the section of that report in which the audit agency again questioned the legality of the combination method?

Mr. TIERNEY. I don't think the audit agency, however, says or purports to say—and I would be happy to be corrected, I don't have that report before me——

Mr. NAUGHTON. Let me read the language into the record.

Mr. TIERNEY. I think I know the language you are referring to, about the possibility of inclusion, through the combination method, of delivery room care.

But, it does not reach the conclusion that by the use of that method, we are overpaying hospitals or are paying hospitals more than the cost of medicare services to medicare beneficiaries. And this, I think, was the ultimate congressional mandate, that we pay the hospitals the costs of care.

This, as I said before, is in our mind a legitimate estimate of how to go about paying the costs of care.

Mr. NAUGHTON. Well, if the Congress wanted you to pay the cost of delivery rooms, why didn't the Congress say you are welcome to place the costs of delivery rooms in the costs paid by the medicare program, so long as you don't pay too much money?

In other words, put in any kind of bill you want, just make it fair.

Mr. TIERNEY. Congress didn't get into that specificity, obviously.

Mr. NAUGHTON. Let me read what the audit agency said on February 5 of this year. I am quoting from their report: "A large proportion of hospitals are computing their medicare costs by the combination method simply because this method produces a greater, though less accurate, reimbursement than does the departmental method. Most importantly, the combination method of cost apportionment permits a hospital to be reimbursed for costs applicable to private room accommodations and to delivery rooms. Each of these types of costs appears to be specifically excluded from reasonable costs as defined in the medicare law.

"While the total dollar effect nationwide of the inclusion of private room costs in hospital reimbursement is not available, information developed by one intermediary shows that for the largest cost hospitals"—and this is for one hospital—"these costs can range as high as $1 million annually."

That is the cost for one hospital, the extra amount paid by medicare.

Now, are you aware of any other studies or statistics that have been made that might give some idea of how much more the medicare program is paying because you are allowing the use of the combination method?

Mr. TIERNEY. Mr. Naughton, no, I am not aware of it.

I would like to call your attention to the provisions of the law with regard to reasonable costs. You quoted the section which said——

Mr. NAUGHTON. I quoted the opinion of your HEW auditing agency.

Mr. TIERNEY. Earlier you quoted the section of the law which said medicare would attempt to make payments for their beneficiaries so their costs would not be share by the general public and vice versa.

In Section 1861(V)(1) of the law, the Congress gave the Secretary the right to establish regulations in this regard and directives.

It said in this effort to determine the reasonableness of costs:

> The regulations may provide for the determination of the cost of service on a per diem, a per unit, a per capita, or other basis; may provide for using different methods in different circumstances; may provide for the use of estimates of costs of particular items of services; and may provide for the use of a charge or a percentage charge where this method reasonably reflects the costs.

It seems to me it is quite clear there that the Congress was not saying that you are going to go right down the line of every single service that a hospital renders to every single old patient and cost it out. It said you are going to make the best efforts you can to come up with a mechanism which will carry out this intent of the law, whether through estimates, whether through an evaluation of charge data, through whatever mechanism the Secretary finds appropriate.

I think we can argue endlessly about whether or not the inclusion or exclusion of a single item of service in a total hospital operation should or should not be included. But I think the ultimate goal, as I

said before, is a mechanism which meets the intent of this law to pay the reasonable cost of the total care provided to medicare beneficiaries by that institution.

Mr. NAUGHTON. Of course, the audit agency figures on one hospital alone indicate that the combination method results in a cost to medicare of $1 million a year more than the departmental method would have produced.

Mr. TIERNEY. I do not think the audit agency concludes from that that what has been paid the hospital exceeds the reasonable cost of the hospital.

Mr. NAUGHTON. The difference is $1 million.

Mr. TIERNEY. Mr. Naughton, I might state to you there is practically no additional cost in a private room. When you go to a hospital and get a private room you pay more, but there is very little differential between actual cost of operating a two-bed room or a private room.

You can get into the niceties of allocating square footage by bed and whatnot. But it is virtually impossible to pin down unless you have some very arbitrary rules. You simply take the ratio of charge and assume the hospital sets its charges appropriately and therefore that represents the difference in cost, the difference in the cost of having one patient in a room and the cost of having two patients in a room. It just is not that simple an approach.

Mr. FOUNTAIN. Mr. Naughton, you did not read all of that section of the HEW audit report. Give the record the benefit of their response.

Mr. NAUGHTON. All right.

Continuing on the next page—I did not read quite all of this recommendation by the audit agency:

> In commenting on our recommendation that steps be taken to have the combination method of cost apportionment deleted from the code of federal regulations, the Social Security Administration stated that it is not possible to make a decision on eliminating or modifying the combination method until a current study of the whole area of medicare reimbursement is completed.
>
> We do not concur with SSA's position on this matter and believe that prompt action should be taken to discontinue the payment of costs that are not allowable charges to the program.

Mr. FOUNTAIN. Do you have any further comment, Mr. Tierney?

Mr. TIERNEY. Only to point out, Mr. Chairman, as Mr. Naughton did, that this is a report of the audit agency which was submitted on February 13 and we quite obviously will take cognizance of their recommendations.

We hope very much, in line with the entire questioning and testimony of yesterday, that we are going to get off of this whole idea of retroactive cost reimbursement, because I do not think it will ever be a satisfactory mechanism and 5 years from now you and I would be arguing about whether or not one method of reimbursement was better than another.

We think it is appropriate, in the meantime, to go ahead with what we have, because we feel that in the overall we are not meeting the total hospital costs, particularly since the elimination of the 2 percent factor.

Mr. NAUGHTON. And you are not concerned about the fact that your general counsel's office said this is not legal and that the HEW audit agency has questioned the legality?

Mr. TIERNEY. We are concerned about the fact, but we have never been confronted by an allegation that what is happening here is resulting in the payment of unreasonable costs.

Mr. NAUGHTON. You are aware, of course, that if a Government agency makes payments that are not authorized by law, that those payments can be recovered?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. In fact they must be recovered.

Now, going back to the difference applicable to the delivery room components of the combination method, did your people at any time attempt to check over those cost reports that were coming in, where they actually had enough information to use the departmental method, but picked the combination method, presumably because it would get them a higher reimbursement?

Mr. TIERNEY. We have, Mr. Naughton, as you well know, a hospital cost analysis section in the Division of Reimbursement which is constantly analyzing the hospital costs as they come in in an effort to develop statistical comparability data. I assume that those studies have been made.

Mr. NAUGHTON. Were they ever communicated to you? Do you have anybody here that can tell us whether a study has been made and what it showed?

Mr. TIERNEY. As you know, Mr. Naughton, the very basic distinction here between the two methods, that is, under the one you have charges by department; under the other you have charges in total. So without the availability of charges by department, you cannot make this study.

Mr. NAUGHTON. Many of the cost reports that were filed actually contained data by department—the hospitals figured it both ways and then took the method that would get them the most reimbursement. The General Accounting Office personnel in Baltimore analyzed 54 costs reports on which there was sufficient data to figure the costs both ways, and each of these hospitals had used the combination method.

The General Accounting Office personnel refigured these from the data that was right on the cost report by the departmental method and the difference for 54 hospitals was $784,146. In other words, for 54 hospitals, according to the computations made by GAO, the cost reimbursement paid to the hospitals by medicare was $784,146 more than it would have been had you required that the departmental method be used.

Now, if you get $784,000 from just 54 hospitals, about how many hospitals do you have using the combination method?

Mr. TIERNEY. I am sure we have that figure.

Mr. FOUNTAIN. Of course, it is optional for the hospitals to use whichever plan they want, isn't it?

Mr. NAUGHTON. Certainly.

Mr. TIERNEY. We have under the combination method 1,166 hospitals, Mr. Naughton. I would point out, as the chairman mentioned, these hospitals have this option under the regulation. They are not foreclosed from using the combination method.

Mr. NAUGHTON. Of course, if the regulation is contrary to the law, they do not really have that option, do they? At least they do not

have the option of putting delivery room costs in to be reimbursed by medicare.

Mr. TIERNEY. Mr. Naughton——

Mr. NAUGHTON. Or if they do have the option of putting it in, you do not have the option of paying it.

Mr. TIERNEY. Oh, I think we do, sir.

Mr. NAUGHTON. But your general counsel's office and your audit agency question it.

Mr. TIERNEY. The general counsel's office has questioned, as does the audit agency, whether or not this is an appropriate reimbursement mechanism. It has never questioned whether or not it actually represents an over or underpayment of the reasonable costs of medicare beneficiaries, which is after all what we are after.

Mr. NAUGHTON. I might mention that the figure that I gave you, the $784,000, is for 6 months, not for a full year.

Mr. BROWN. May I ask, as long as he gave the figure for combination accounting method, could you give me the figure on the full departmental method of reimbursement?

Mr. TIERNEY. This was an analysis of some reports submitted for the first cycle of audited cost reports, Mr. Brown. Those using the departmental RCC, there were 201, or 8.2 percent; the combination with cost finding, which is the method that Mr. Naughton has been discussing with me, 1,087 or 44 percent; the combination with the estimated percentage mechanism, which was available in the beginning, which is no longer available, were 1,166, or 47.2 percent; and the number using the gross RCC, which again was available in the beginning but no longer, was 15, or .6 percent.

Mr. BROWN. Thank you.

Mr. FOUNTAIN. Mr. Tierney, it seems to me the basic question which might be posed as a result of this information is if the departmental method is the more accurate, certainly in those cases where the hospitals can use it—and in these instances they used both—then the question is why not follow or make mandatory that method.

I am not expressing an opinion on it, but I am raising the question for any response you might have to it.

Mr. TIERNEY. Mr. Fountain, my only answer to you, sir, would be that while it may be deemed, from an accounting point of view, more accurate, I do not think it represents an absolute guaranty that what we are paying is the full cost of medicare services to beneficiaries.

Now, you can get accountants who say, well, that is the most accurate accounting method. You are faced, however, in this Nation with 7,000 institutions whose current and unanimous position is that even under that method and even under the combination method we are not meeting the costs of hospital services to medicare beneficiaries.

I do not think, Mr. Chairman, that you solve that basic problem by specifying accounting procedures. There have to be some further judgmental factors brought into the picture.

Mr. FOUNTAIN. Of course you are taking into account some intangibles for which hospitals may be entitled to compensation, which you feel they may not be adequately paid for, but isn't it the responsibility of the hospitals to satisfy you about those costs, so you can take that into account in the consideration of a new formula?

From your point of view in determining the costs, as to what should be paid, particularly in view of the increasing cost of hospital care and medical care, would it not be desirable to determine the most accurate method which would reflect the amount which you should pay consistent with the requirements of the law?

Mr. TIERNEY. Yes; I agree with you, sir. That was the 2-percent allowance that we discussed earlier was deleted from the regulations.

What we have tried to do there is make an intense statistical analysis and survey of the actual cost differentials involved in routine nursing services for aged people, as opposed to others. This, some studies have been made on, and we think we may come up with a figure that will represent that.

The other areas that I spoke about, Mr. Chairman, where the assertion is made, and it is very difficult to prove, that older people not only in routine nursing service, but throughout the hospital, cost more to take care of, we simply don't have sound data to operate on.

Now we could take the position that until you prove it, we just deny it. I think intuition and logic tells you that would be an arbitrary position that would result in our underpayment of costs to the hospitals.

I really think, as I have said before, the ultimate solution lies in a different approach.

Mr. FOUNTAIN. I quite agree with you, and I agree with their contention. I think the facts of life are such that it would cost more, take more time to care for the elderly patients. I have a sister who is totally paralyzed—totally except for one side—and she can't walk. They just recently had to take her from a nursing home over to a hospital and it took them quite a while to get her on the X-ray table. I am sure they spent four or five times as much time with her as they would with an average individual.

Mr. TIERNEY. That is the point, Mr. Fountain. We didn't allow that hospital to charge a penny differential between taking care of her and someone else.

Mr. FOUNTAIN. I understand that.

But it seems to me you are engaging in a speculative approach when you attempt to pay for that in a general way, without some specific formula. That is why I think it is extremely important that you continue this process of trying to find a more accurate manner of being fair to the hospitals and at the same time being fair to the medicare program.

Mr. TIERNEY. I totally agree with you, sir. There has been no segment of our total operations that we have spent more time and effort on in the last 8 months.

Mr. NAUGHTON. You do have solid data on the number of medicare patients who use the delivery room, or don't use it? There is no question about that, is there? That is no great accounting problem?

Mr. TIERNEY. I think we could develop that data, Mr. Naughton.

Mr. FOUNTAIN. Any other questions in this area?

Mr. BROWN. I would like to ask a question on the philosophy of the Social Security Administration with reference to this whole problem.

Are you thinking in terms of assisting hospitals with their increasing costs when you pay for medicare patients, or are you thinking in

terms of paying what the Federal Government is responsible for, the cost of caring for those medicare patients?

I want to be sure that we are working from the same philosophical base.

Mr. TIERNEY. Mr. Brown, there is no question about the basic philosophy of the Social Security Administration or the Department in this case, or in this program, and that is that medicare was a program designed to cover the costs of health care of the aged. It wasn't designed to help assist hospitals with their financial problems, nor doctors, nor providers, nor nursing homes, nor anybody else.

Our interest is in the beneficiary, and in as fully as possible carrying out the intent that the reasonable cost of their care be covered.

Now hospitals make great assertions that it should be a part of this program to make contributions to their capital needs—their capital needs are very great. The hospital system in this country is badly underfinanced.

Our position is, that is fine, but that is not for the aged to take care.

Mr. BROWN. I would suggest the Federal Government is also taking care of that problem. I sit on another committee in the Congress which has that as its primary responsibility, Interstate and Foreign Commerce. We have jurisdiction over many and various programs designed to assist the development of hospitals—modernization, the planning of them, the innovation of the hospital design, a lot of things like that, which are entirely different, I would think, from your responsibility to the law as passed by the Congress, to pay the reasonable costs of these patients.

Mr. TIERNEY. That is right, sir.

Mr. BROWN. Let me ask you this: Do you think it should be necessary for the law to have written into it the accounting procedures which should be used to determine what those reasonable costs are?

In other words, is the language "reasonable costs" insufficient to provide you the opportunity to successfully administer this program in the interests of the economy and efficiency of the Government?

Mr. TIERNEY. I think it would be a mistake, Mr. Brown, to try to write into the law a specific accounting or reimbursement mechanism which would be applied to every hospital in the Nation, large, small, teaching, nonteaching, religious, or anything else.

Mr. BROWN. I agree with you.

Mr. TIERNEY. I do agree with you sir, that the term reasonableness whether it is in this program or any other context, is always a subject of debate. But I think the law has given the Secretary authority to either, on a per diem basis, per capita basis, an estimate basis, ratio of charge basis, or on an acceptable accounting basis to do the very best job that is possible, of estimating the reasonable cost of care to medicare beneficiaries.

I don't know how much more specific the Congress can get than that. I don't think an accounting or reimbursement procedure should be structured in the law.

Mr. BROWN. Whose responsibility, within the Department of Health, Education, and Welfare, down through the Social Security Administration, is it, do you feel, to develop the formula or formulae which would be applied to determine what those reasonable costs are?

Mr. TIERNEY. Well, the chain of command in the administration of the program, sir, is the Bureau of Health Insurance, of which I am the Director, in charge of the operation and administration of the program, and of making these judgments.

Obviously the ultimate authority over the program lies in the Office of the Secretary. Regulations which are promulgated are promulgated in his name. I am not trying to pass on responsibility, but quite obviously that is the way the command operates.

Mr. BROWN. I think your answer is appropriate.

Should there be varying formulae for different circumstances, or should there be a principle of hospital cost allocations with regard to medicare patients that is applicable in some broad way to all hospitals which handle medicare patients?

Mr. TIERNEY. We had a discussion yesterday, Mr. Brown, about the desirability of getting off of retroactive cost reimbursements and on to a prospective establishment of a target rate which would eliminate all of the niceties of retroactive adjustments——

Mr. BROWN. But we aren't there yet. That is not what I am asking.

I am asking, under the present system, which is retroactive, whether there should be different formulae, either applied by you or utilized by the hospitals, at their discretion to permit them to test the cost of caring for their patients as to the reasonableness in various ways?

Mr. TIERNEY. I think, Mr. Chairman, we have put out a series of principles of reimbursement. These have been put forth ultimately in the form of regulations.

Obviously you have a tremendous spectrum of institutions in the hospital system of this Nation, ranging from the very large medical school-oriented hospital where you have an absolutely different scope of service than from the little hospital in the rural area.

I don't know, sir, that we have had experience enough to date to know whether or not you should apply the same absolute criteria to both. I think if you can approach things on prospective basis and establish what the scope of service is, what does the community need and therefore what is reasonable to pay, possibly you can make those differentials.

At the moment we are trying to apply common principles to every single institution in the Nation, and that is an administrative problem, frankly.

Mr. BROWN. Not a question, but an observation: It seems to me then that is the purpose of these hearings to determine what is reasonable in these reasonable costs, and to get some kinds of a formula which you can use in either retrospective application as to whether or not the hospital has charged a reasonable cost, or in prospective application to what those costs should be, or how those costs should be allocated and tested in the future when you go back and audit what you have permitted in advance for medicare patients.

I wonder in either case, whether the hospital should be in a position to apply its own accounting formula to serve whatever its own purposes are.

I grant that hospitals are wonderful institutions, interested in the care of their patients and the service to the community and so forth and so on. But I don't doubt also that there may be some hospital administrators, even nonprofit hispital administrators, who would

like to load it on the Government and let the patient get by with somewhat less that his share of cost if he is going to have to pay for it out of his own pocket.

Mr. FOUNTAIN. Dr. Goldberg, who is presently studying another facet of the health problem, has a question.

Dr. GOLDBERG. Mr. Tierney, is it your thinking that hospitals in general have not developed their financial management and their accounting systems to the point where one could compare them favorably to efficient corporations in the private sector?

Mr. TIERNEY. You are asking me for a judgment, and I don't mean to make a blanket indictment, but I think it is fair to say that because there has been no reason in the past for the hospitals, prior to medicare, that they probably devoted much less effort to the niceties of cost accounting than to business generally. Medicare was the first program that ever came along that said to a hospital, from now on, instead of being paid on an average per diem on some other basis, you are going to have to start to try to allocate out in a more refined maner the cost in your institution, and apply it to these people.

So I think it is a fair judgment and I don't think it is an indictment of the hospitals that they have not had that capacity in the past.

Dr. GOLDBERG. I quite agree with you.

I hadn't intended the question to be critical in nature or tone. I simply wanted to ascertain whether this was the thrust of what you had been saying earlier.

Now, in the same connection, are there substantial differences in capabilities between hospitals? Have some hospitals developed very effective accounting systems that reflect quite accurately the actual costs of providing services for classes of patients?

Mr. TIERNEY. There are a number of undertakings in the country, Dr. Goldberg, which you are undoubtedly familiar with, the CASH program in California, the HAS program in the Midwest, where there has been a great effort to develop common cost accounting procedures for participating hospitals and data which theoretically brings about ultimately a basis upon which comparability studies can be made.

I think this is a developing thing, and I am quite sure, sir, that there are institutions that do a much more adequate job than others. I find it difficult, without going back and making a further survey, to identify them for you.

Dr. GOLDBERG. I would not want you to identify particular institutions. What I am asking you to respond to is simply whether from your own knowledge you could say there are a group of hospitals in this country that have very accurate cost accounting systems.

I will mention one hospital, not that I am personally familiar with it, but that I have heard referred to many times as being a very efficient institution in its financial capabilities—Massachusetts General Hospital.

Mr. TIERNEY. I know Massachusetts General has that reputation. Nevertheless, we have a number of problems in dealing with Massachusetts General, quite separate and apart from their accounting capacities, because of other reasons or provisions in the law that we have not been talking about here. But I think I would agree with you that Massachusetts General has done a good thing.

Interestingly enough Massachusetts General has approached us on

the basis of talking about an all inclusive rate. Forget the whole business of breaking down services and breaking down departments and breaking down costs. Let's have an all-inclusive rate situation, which as you may know, Doctor, was a situation that prevailed largely 35 years ago in the hospital and from which they gradually departed into this charge system.

So when you say do they have a very effective cost accounting system, yes, but their philosophy is that over the long range in the future perhaps hospital care should be financed not through that kind of a cost accounting system, but by the establishment of an all inclusive rate.

Dr. GOLDBERG. I recognize the merit of what you are saying, and I think it buttresses the fact that in every similar situation there is somewhat an adversary relationship between the payor and the payee, whether it be in the grant or contract area or in an operation such as yours. The person on the receiving end will always have differing opinions and attitudes and want more. This is the nature of the game.

I think the part of this series of questions that interests me most is this: If I understood correctly the thrust of what you were saying earlier, as between the departmental method of accounting and the combination method, the former produces more accurate results, assuming that it is being done well within the institution.

Is that a correct statement?

Mr. TIERNEY. Yes, sir, that is correct, assuming it is being well done and, assuming as I am sure you mean in saying, that it is well done that the charges reasonably are related to and reflect the costs.

Dr. GOLDBERG. Which a good postaudit would disclose.

Mr. TIERNEY. An exhaustive postaudit, yes, sir.

Dr. GOLDBERG. Yes. Earlier Mr. Naughton made reference to a study, I believe it was a GAO study, which identified 50-some-odd hospitals which had computed their costs both ways.

Obviously they had the capability of using the more accurate departmental accounting method.

These hospitals found that the combination system provided them with the largest return and they so claimed.

Under those circumstances, what is the justification of your allowing those hospitals to take the higher figure? Is this in the nature of an offset because of the elimination of the 2 percent factor? Is that your philosophy?

Mr. TIERNEY. No, sir.

As I traced the development of this whole reimbursement mechanism from the beginning, we started out with four permissible operations. We have sliced off one and we have sliced off the ultimate here, Doctor, is a matter of time. We are now engaged in an effort to very soon develop a whole new approach and we have not seen fit to date to slice off still a third and leave the hospitals of the Nation with only one mechanism by which they can claim reimbursement.

Dr. GOLDBERG. I am not asking that. I am trying to ascertain why, in circumstances where you know the hospital has the capacity, indeed has gone through the paper work of doing a departmental audit, you would not insist that reimbursement be made on that basis, rather than on the basis of a combination method which provides a higher figure?

Mr. Tierney. I suppose the alternative always would lie with the hospital, Doctor. They simply would give up the cost accounting system they had and use the combination method as long as it is available.

We are not in a position, Doctor, to prescribe accounting systems for hospitals. All we can insist upon is that they file cost reports in accordance with our regulations and that they have the data that we can audit and substantiate. But we are not in a position to tell any hospital "You will use such and such an accounting system."

Dr. Goldberg. I appreciate that. Just one final question.

Do you require that the hospitals receiving payments under medicare apply the method they use for reimbursement from you consistently for all purposes, or do you allow them to use more than one method?

Mr. Tierney. Well, I don't know that I understand your question. They obviously are allowed to do anything they want, to charge people who are not covered by third party payment of some sort. They have another method of being reimbursed by whatever local Blue Cross plan they are in.

Now the cost figures, the basic data, are all the same. But they don't have to accept reimbursement from Blue Cross on the same basis they accept it from us.

The General Accounting Office made a study, I guess it was a year or two ago, of whether or not medicare was paying more than the local Blue Cross plan was paying in 10 selected areas around the country and it found that in nine of the areas the local Blue Cross plan was paying more, on an average per diem basis, than medicare; in one medicare was paying more than Blue Cross on that basis.

Now some of the plans were paying charges while others were paying cost. But as you well know, Doctor, the term "cost" is meaningless unless you know what is included in the cost.

Dr. Goldberg. Yes. I appreciate that.

Mr. Tierney. I am trying to answer your question. There is this requirement, they can't have a different charge schedule for medicare than they have for all of the other patients, because that is an integral part of the ultimate determination of the cost of medicare. So they have to charge everybody the same.

Dr. Goldberg. But they can obtain reimbursement from Blue Cross or some other third party payor under the departmental method and they can turn around, after having made that kind of computation, and receive payment from medicare under the combination method?

You don't say, like Internal Revenue, that the institution has a choice of cash or accrual accounting, can be on a calendar or fiscal year basis, and so forth, but has to be consistent from one year to the next.

Mr. Tierney. They have to be consistent from one year to the next with us unless within certain time limits they obtain permission from the intermediary to change. But what they do with other third party payers, we have no way of knowing.

Dr. Goldberg. I am just expressing a personal opinion. I come away with the very distinct impression that, under the circumstances, where you know a group of hospitals not only have the capacity but are, in fact, on a departmental accounting basis and you permit them to obtain a higher reimbursement by calculating costs another way, you, in

effect, are giving them a bonus. And while under your regulations this is a permissible arrangement, there is no denying that, I think the crux of the matter is whether this ought to be permissible—whether this is an accurate reflection of true costs.

We spoke earlier about various intangibles that might not get reflected in costs. I don't question that this would be true in hospitals with unsophisticated or less sophisticated methods.

But when you are dealing with hospitals that have highly developed systems, I can't personally see any rational basis for saying: "Take a choice, fellows; after you have done very accurate accounting, we will allow you to claim a higher figure through a less accurate method."

Mr. TIERNEY. I think I have restated our position, Doctor. And you don't agree with us.

Dr. GOLDBERG. That is right. In your earlier testimony, you made simultaneous reference, and I was trying to ascertain whether the two things had a causal relationship, to allowing hospitals to choose the combination or the departmental method and the elimination of the 2-percent factor. Whether you intended it that way or not, I came away with the distinct impression that you were trying to soften the blow to the hospitals.

Mr. TIERNEY. I think not at all, Doctor, and I would welcome the opportunity to correct that impression if that was the impression I left with you.

At the time that the decision was pending as to whether or not the time had come to modify the combination method, there was an elimination of the 2-percent factor, which was supposed to cover all of these unidentifiable but, nevertheless, recognized cost differentials. And we were then under a mandate to develop a new mechanism.

Whether you say soften the blow or not, I don't think that was the motivation. The motivation was that there had been in the regulations a mechanism which was designed to cover the unidentified costs for the aged. It has not been modified and we were going to try to get a new formula. It did not seem appropriate at that time to make further changes in the regulations.

Dr. GOLDBERG. Thank you.

Thank you, Mr. Chairman.

Mr. FOUNTAIN. We just had a second call for a quorum. In the hope of at least getting another section we would like to ask some questions about health and safety standards.

The committee will take a recess for 15 minutes and hope we can return and get in at least another 45 minutes, if that is satisfactory to you.

The committee stands recessed until 11.50.

(Short recess.)

Mr. FOUNTAIN. The committee will come to order.

Mr. Tierney, I would like to ask some questions now in the area of health and safety standards.

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. Before being approved for the medicare program, are extended care facilities required to meet minimum standards for health and safety?

Mr. TIERNEY. Yes, sir; they are. We have conditions of participation as we call them, for all institutional participants, and as I think I told you in our original testimony, Mr. Chairman, the State agencies, the State health departments of the Nation, conduct the surveys under agreements with the Secretary.

They go into the facility, they inspect it, and they certify it as meeting the requirements not only of the State law, of licensure, of course, but also the requirements of the medicare regulations. That is how they become certified.

Mr. FOUNTAIN. So I assume you would agree that an adequate number and quality of nursing personnel is essential if an extended care facility is to provide adequate health care?

Mr. TIERNEY. Yes, sir; that is one of our conditions of participation.

Mr. FOUNTAIN. Is it true that the conditions of participation require that an ECF must have a registered nurse in charge of at least one 8-hour shift out of each 24 and there must be either a registered nurse or a licensed practical nurse in charge of the other two shifts?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. Is there any specific requirement as to the maximum number of patients one nurse can serve?

Mr. TIERNEY. No, sir. We have not established what you would call a nurse-patient ratio. This is a very difficult thing to do, Mr. Fountain. It depends entirely on such factors as patient mix and their needs, the physical layout of the facility, the functions assigned to the nursing service and the patient care policies of the facility.

In the development of our criteria or our conditions for participation, I think I also told you on Tuesday we had a major input, major consultation with the Public Health Service, and with such organizations as the American Nursing Association and other qualified experts in the field.

They recommended strongly against the establishments of any precise patient-nurse ratio on the grounds that among other things when you set minimums, they tend to become maximums. Only within the past few months the Public Health Service reiterated that nurse-patient ratios not be established as a requirement for medicare participation.

They felt in their professional judgment that it was not, it would not be good judgment to try to establish any kind of a minimum nurse-patient ratio. So we do not have that, sir.

Mr. FOUNTAIN. I appreciate the merit of that contention. And yet insofar as any specific requirement of the conditions of participation, you could have two or 300 patients in an ECF served by only one nurse; could you not? Or could you?

Mr. TIERNEY. I suppose you could for a very short time, Mr. Fountain. On a given night, if everybody did not show up, that might happen. But our basic requirement is that there be adequate nursing personnel on hand and we would not tolerate any such situation as that.

Mr. FOUNTAIN. Maybe that is an extreme example. But you could have in many instances twice as many patients, I guess, served by the same number of nurses in one institution as in another.

Mr. TIERNEY. Our condition of participation in this area. Mr. Fountain, reads that "the institution must provide 24-hour nursing service

which is sufficient to meet nursing needs in accordance with the policies developed" in paragraph 2, "and has at least one registered professional nurse employed full time." That is not only the regulation, but it is a part of the law.

Mr. FOUNTAIN. Are any spot checks made to determine whether or not they do have adequate nursing at the institution?

Mr. TIERNEY. Yes, sir. Checks are made routinely by not only the State health department, which as I have indicated, is the carrying agency, but by intermediaries, by people from our own regional offices, and by some visits that we made from the central office.

Mr. FOUNTAIN. Who has the responsibility for inspecting ECF's to determine whether or not they are in compliance with the conditions of participation?

Mr. TIERNEY. The State health department in each State.

Mr. FOUNTAIN. You rely upon them?

Mr. TIERNEY. Yes, sir. The law specifies that the Secretary shall contract with the State health agency or other appropriate State agency for these purposes.

Mr. FOUNTAIN. Mr. Naughton.

Mr. NAUGHTON. Mr. Tierney, I am not sure I follow the logic behind your statement that when you have a minimum ratio that the minimum tends to become the maximum. Could you not require adequate nursing service and provide specifically that unless you have at least one nurse for every 50 patients or 40 patients, or whatever a desirable minimum is, it shall not be considered adequate?

In other words, you have to have this ratio or you are automatically not adequate. But you may not be adequate even if you have that, depending on the type of patients you are taking care of and so forth if you are clearly not rendering the service that should be rendered?

Mr. TIERNEY. Well, you certainly could do that, Mr. Naughton. I think the real test of whether or not staffing is sufficient is the verification that restorative nursing is being provided in accordance with our regulations and that the amount of skilled nursing care required for a viable and safe protective environment is maintained.

I can only tell you again, sir, that the Public Health Service, and national professional nurse organizations, were very specific in recommending against setting any such ratios, because they thought it would be wasteful in many situations where that kind of a level was not required and would tend to, as I say, become a maximum. You might get other judgments from other people. But these are people who have vast experience.

Mr. NAUGHTON. Do you have correspondence from the agencies you mentioned that you could supply to us indicating their opposition to minimum standards?

Mr. TIERNEY. I will have to find out whether that is in the form of correspondence.

Mr. NAUGHTON. Do you also have communications from others who strongly urged you put into effect a minimum ratio?

Mr. TIERNEY. I am not aware of any such correspondence.

Mr. NAUGHTON. Would you supply those also, if you have any?

(The following information was later supplied:)

The only correspondence on nurse-patient ratios in extended care facilities was from the American Nurses' Association. The organization's enclosure to the letter dated April 18, 1967, stated that it does not recommend any specific formula, ratio, or numerical concept. The letter and enclosure follow.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., April 18, 1967.

COMMISSIONER ROBERT M. BALL,
Social Security Administration,
Department of Health, Education, and Welfare,
Baltimore, Md.

DEAR COMMISSIONER BALL: I am pleased to enclose the statement on nursing staff requirements for inpatient health care services which was recently prepared by the ANA Committee on Nursing Services and the staff of the Nursing Services Department. This statement suggests a recommended approach for determining nurse staff requirements for inpatient health care facilities. It is based on the ANA Standards for Organized Nursing Services and outlines the factors affecting staffing which must be taken into consideration in determining needs for individual units and institutions.

It is hoped that those nurses who are responsible for determining and supporting staffing requirements will find this statement of assistance in evaluating their present patterns and stimulate study and research in the development of new types of staffing plans. It is recognized that the standards related to staffing represent a goal to be achieved for many departments which are faced with serious shortages of nursing personnel. This statement then might be used also as a discussion point to support the effort of the staff to improve utilization of all personnel by appropriate delegation and assumption of functions throughout the institution.

Additional copies of this statement are available upon request at no cost from the ANA Order Department.

We are pleased that the American Journal of Nursing Co. is planning to publish the statement in an early issue.

Permission to reproduce the attached statement is granted when full credit is given to the American Nurses' Association in the reproductions.

Comments and suggestions about how this statement can be improved when revised will be gratefully received.

Sincerely yours,

PAULINE M. FAHEY, R.N.,
Assistant Director, Nursing Services Department.

STATEMENT ON NURSING STAFF REQUIREMENTS FOR INPATIENT HEALTH CARE SERVICES

INTRODUCTION

What is the number of nursing personnel required to provide "adequate" nursing care? How many nurses are needed to staff a 150-bed hospital? What is a desirable ratio between registered nurses and auxiliary personnel? These and similar questions are raised daily as health care administrators, nursing service administrators, Government agencies, and community health leaders seek specific recommendations on numbers or ratios of nursing personnel needed to staff health care facilities.

The American Nurses' Association does not recommend any specific formula, ratio, or numerical concept which could be applied generally to any inpatient health care facility because of the multitude of factors which must be taken into consideration for each situation in determining staffing needs. The association does recommend that the director of nursing and her staff develop individual staffing patterns for each patient care unit or department taking into consideration "Standards for Organized Nursing Services" [1] but specifically standard No. 6 and four of its assessment factors, which say:

> "The nursing department promotes safe and therapeutically effective nursing care through implementation of established standards of nursing practice."

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[1] *Standards for Organized Nursing Services,* American Nurses' Association Code No. NS 2.

(*a*) "Registered nurses review and revise nursing care programs as necessary."

(*b*) "A registered nurse plans, supervises, and evaluates the nursing care of each patient."

(*f*) "A registered nurse assigns the nursing care of each patient according to the needs of the patient and the preparation and competence of available staff."

(*g*) "A registered nurse gives nursing care to patients who require her judgment and specialized skills."

With these standards as a basis, these decisions should be made for each situation:

(1) How many patients can one R.N. plan, supervise, and evaluate nursing care for, and at the same time;

(2) How many auxiliary personnel can one registered nurse direct, supervise, and evaluate;

(3) How many patients will require the direct care of a registered nurse and how much nursing time will be involved in this care?

Additional considerations

The following policies, practices, and factors should also be determined before the nurse staffing requirements can be established:

(1) The purposes and objectives of the health care facilities and the nursing service department, including the standard of patient care established and supported by the health care facilities.

(2) The assigned responsibilities and functions of each department and their employees in relation to services to patients, especially as these affect the amount of nursing time spent on activities not directly related to nursing care.

(3) The number of physicians referring, visiting, and directing the medical care of patients within the health care facility.

(4) The level of activity throughout the hospital and within each nursing unit, such as patient turnover, number and complexity of operations, diagnostic procedures, treatments and medications.

(5) How often and for how long does the patient have to leave the nursing unit for special procedures and treatments?

(6) The intensity of illness, the nursing needs, the degree of dependence, and the age distribution of patients cared for within the health care facility and the placement of these patients within the various nursing units.

(7) The physical layout of the total institution, the relationship of individual departments to each other, the size, geographical layout, number of beds, type of accommodations, the proximity to other hospital departments of each nursing unit, and the number and type of specialized nursing units.

(8) The quality and availability of supplies, equipment, and supportive personnel and services to the patient care units over the 24 hours of the day and 7 days of the week.

(9) The number, level of preparation, and assigned functions of all nursing personnel and the time required to bring new nursing employees to the level of their job expectations.

(10) The method of patient care assignment employed by the nursing department.

(11) The quality of nursing administration and supervision available.

(12) The method of assignment and the number and level of competency of private duty nurses normally available and employed by patients or the health care facility.

(13) The amount of time spent by nursing service personnel in teaching and research activities.

(14) The amount of nursing time spent in planning for continuity of patient care.

One estimate that is helpful in determining the basic requirements for nursing personnel for the health care facility is that on the basis of a 40-hour or 5-day work week it takes 4.2 persons to provide one employee on duty in any one situation 7 days a week 24 hours a day. However, this figure allows no leeway whatsoever for holidays, sick leave, time off for staff development, meetings, vacations, and leave of absence.

In order to determine accurately staffing needs, the director of nursing should have access to complete staffing data compiled regularly for the nursing depart-

ment which indicate average sick time, leave of absence, vacations, staff development needs, and turnover rates.

Because needs within each unit can fluctuate daily, adjustments may have to be made in staffing patterns to meet these changes. Many nursing departments have established a pool or reserve of part-time nursing personnel especially oriented who can be assigned on a daily basis whenever needs occur. These pools can decrease the need to move regular nursing personnel frequently from their own areas of assignment resulting in decreased efficiency and weakened continuity of patient care.

All staffing patterns need to be reevaluated at regular intervals on the basis of current staffing standards, statistics, changing needs, patterns and practices. Experimentation must be encouraged to achieve more effective utilization of all nursing personnel and constant upgrading of the quality of nursing care.

Mr. NAUGHTON. You indicated that your standard requires 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the needs of the patients. Your definition of nursing personnel includes aides and orderlies, does it not, as well as registered professional nurses and licensed practical nurses?

Mr. TIERNEY. Yes. There is this basic requirement that there be a registered nurse, and that there be licensed practical nurses and there be other appropriate nursing personnel.

Mr. NAUGHTON. So we are pretty much back to the mandatory requirement of one nurse, either registered or a licensed practical nurse per shift. Beyond that maybe they might have aides and orderlies, but you get to a judgment question.

Mr. TIERNEY. I might point out, Mr. Naughton, that this is not unique in this program or in the hospital field, for example. The Joint Commission on Accreditation of Hospitals which has been in existence for 30 years, and which represents as you know the hospital association, the American College of Surgeons and American College of Physicians, do not mandate patient-nurse staffing ratios in hospitals. They simply require that there be adequate nurse staffing in the hospitals. And they include in that staffing qualified orderlies and nurses' aides, and other personnel. So that I think what we are doing is in keeping with the established practice of health institutions in the Nation.

Mr. FOUNTAIN. What are the qualifications required of the surveyors who make these inspections to determine whether or not the conditions of participation are being complied with?

Mr. TIERNEY. I would stand ready to be corrected on this, Mr. Fountain. I think the regulations specify that the Secretary satisfy himself that the State agency with which he contracts has competent, capable, and sufficient staff to carry out this function. I do not think there are any specifics spelled out as to the qualifications of an individual surveyor.

Mr. FOUNTAIN. Incidentally, at this point let me say if at any time during the course of our questioning some one of your colleagues is in a particular area where he is especially equipped to respond, do not hesitate to call on him.

Mr. TIERNEY. Thank you, sir. I would point out for the record that section 1864 of the law says that the "Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency will be utilized by him for the purpose of determining whether an

institution therein is qualified as a hospital or an extended care facility."

Now, Mr. Levy can respond as to what further qualifications there may be.

Mr. FOUNTAIN. Mr. Levy.

Mr. LEVY. Mr. Chairman, in accordance with the terms of the agreement that we have with each of these State agencies, the State personnel must meet the required civil service and merit system provisions of the State.

Now, generally the pattern followed by the State agencies in surveying facilities is to use registered nurses and others with health care backgrounds such as hospital administrators. Some of the States use physicians to survey the more medically related aspects of these facilities. The States also use sanitarians and other people with paramedical backgrounds. Frequently the pattern they follow is to have a team of these individuals, when they do the survey, so they might have a registered nurse, say, a medical records librarian, and a sanitarian comprising a survey team.

Mr. FOUNTAIN. Again, this is done by the State?

Mr. LEVY. I am referring to the State health departments, yes.

Mr. FOUNTAIN. Mr. Naughton.

Mr. NAUGHTON. Mr. Levy, do all States to your knowledge have fully qualified people with medical backgrounds making these inspections?

Mr. LEVY. Yes, sir.

Mr. NAUGHTON. Are you confident it would not be possible for some State, for example, to hire a used-car salesman or retired clergyman?

Mr. LEVY. I would hope they would not.

Mr. NAUGHTON. Are you certain?

Mr. LEVY. As far as I know the personnel in the States who do the surveys generally have a background in some part of the medical care field.

Mr. NAUGHTON. Now we are talking about the people who actually go out and inspect the nursing homes, walk through the halls, look at the equipment, because you cannot do this from Washington and you cannot do it from a desk in the State capitol.

Are you or are you not confident that all of the surveyors, everywhere, who are making these inspections for the Medicare program are fully qualified?

Mr. LEVY. Mr. Naughton, let me respond to your question this way: The States use the equivalent of 700-some-odd people to do these surveys.

Now, these are people, of course, as I indicated, on the staff of the State health departments. I would not want to say in the 700 we might not have one former used-car salesman, but to my knowledge, the people who are doing these surveys in the nursing homes have some medical background to do the survey.

Mr. FOUNTAIN. Of course, there is nothing wrong with a used-car salesman if he is otherwise qualified. There are some in the Congress, I understand.

Mr. LEVY. I have met some very qualified used-car salesmen, Mr. Chairman.

Mr. BROWN. Would you extend the same courtesy to the clergymen?

Mr. NAUGHTON. Do you have in your possession, or is there available to you, a list of the qualifications of the various surveyors who are making these inspections? In other words, do you know or do you not?

Mr. LEVY. I could submit, if this is what you want, Mr. Naughton, for the States generally the types of skills——

Mr. NAUGHTON. I do not mean generally.

Mr. LEVY. You want individual persons or by individual States.

Mr. NAUGHTON. The total picture. In other words, is there in the United States, anywhere, a used-car salesman or a former clergyman with no other qualifications in the field out checking medicare extended care facilities to see if the health and safety conditions are adequate.

Mr. LEVY. I do not have such information personally.

Mr. TIERNEY. Are you asking for a list of names and qualifications of the 700 people?

Mr. NAUGHTON. No.

Mr. FOUNTAIN. I do not think anyone can expect you to have definite information about every individual used by the State. I think if some situation is brought to your attention—I think the important thing is what are the procedures to check into this sort of thing, to take every precaution that it does not happen.

Mr. TIERNEY. Mr. Chairman, in that regard, Mr. Levy is the assistant director in charge of the division of State operations and he has reports of people who go out and visit every State agency, and who observe and evaluate the job they are doing. On those occasions they also go on site and see whether or not what has been reported in a survey actually does exist.

This, we think, is the most effective administrative technique we have for determining that an agency as a whole is doing its job.

In reply to your question, Mr. Naughton, I would not even want to give you any assurance that there isn't a poor old used-car salesman on a job somewhere out in Idaho today.

Mr. NAUGHTON. I don't know of one at the moment, but——

Mr. TIERNEY. If you ever hear of one, I wish you would let us know.

Mr. LEVY. May I suggest this, the committee may find this helpful. The Association of State and Territorial Health Officers recently completed a very extensive inventory of the qualifications of surveyors—you may have a copy of this.

Mr. NAUGHTON. That is people at the State level. That is not people making inspections.

Mr. LEVY. Yes, they are, these are the people that are going around to do the surveys.

Mr. NAUGHTON. In all cases?

Mr. LEVY. As far as I know, sir.

Mr. NAUGHTON. The question I am trying to get answered, and I think it is fairly simple: Is there anything in your agreements with the States, with every State, that specifically requires basic minimum qualifications for surveyors who are to inspect nursing homes?

In other words, so they would have some experience that would enable them to tell whether the health or safety conditions are met?

Mr. LEVY. Mr. Naughton, the agreement calls, as I indicated earlier, for the personnel employed to do the surveys to meet specific State civil service requirements.

Now the States, at least many of the States I am sure, have specific requirements that the people doing the surveys have health care backgrounds.

Mr. NAUGHTON. Right.

Mr. LEVY. Which they would establish before people could be employed by the States to do these surveys.

Mr. FOUNTAIN. I think Dr. Goldberg has just suggested the basic question may be, are the employees of the State who participate in this kind of activity and perform this service, subject to the State merit system?

Mr. LEVY. Yes, Mr. Chairman, they are.

Mr. BROWN. May I ask a question at this point, Mr. Chairman?

Mr. FOUNTAIN. Yes.

Mr. BROWN. But is the inspection of the facilities and the establishment of requirements for the health standards of hospitals and extended care facilities covered by the same agency in all States?

I would assume, for instance, that in some States the safety standards of a hospital structure might possibly be under the jurisdiction of a State building inspector as opposed to a health department.

Now is that common throughout the 50 States in the country or not?

Mr. LEVY. Let me respond this way, Mr. Brown: To the first part of your question, the actual inspection is done by the State people.

What they are inspecting against, sir, are what we describe as the conditions of participation, which were developed by the Department of HEW in consultation with a number of experts in the health care field and issued in accordance with the appropriate legislation. The conditions do provide that as part of the survey the States survey or must determine that the facility meets all applicable State and local fire and building codes and regulations.

Mr. BROWN. That relates to the specific kinds of facility that it is.

Mr. LEVY. That relates to the specific kind of facility; yes, sir.

Mr. BROWN. In other words, you are operating in this field, if I understand it correctly, under a Hinshaw amendment type of relationship, where you are taking the word of the responsible State agency for the approval of the facility in that State with reference to safety standards as they apply to structural usages? But whose word are you taking with reference to the health standards as they apply to the various aspects of health care?

Mr. LEVY. We are taking the word, sir, of the State surveyor, who is on the staff of the health department.

Mr. BROWN. With reference to health matters.

Mr. LEVY. I am referring to health matters; yes, sir.

He makes his survey against the conditions of participation which have been issued for that class of facility. So if we are talking about extended care facilities, he has a listing of various standards, factors and conditions which go to the health aspect of the facility that he surveys against.

Mr. BROWN. The use of your terms, I am sorry, is confusing to me.

When you say he surveys against, are you talking about Federal standards that he checks against when he makes the survey?

Mr. LEVY. That is right, sir.

Mr. BROWN. What about the State standards? Are the Federal standards generally higher or lower than the State standards?

Mr. Levy. The conditions provide that the facility must meet any appropriate or applicable State licensing requirement. So that is the first thing.

Mr. Brown. Let me stop you there if I may.

Have you done any generalized survey of the State licensing requirements to determine whether or not those requirements are adequate and how they compare to the Federal standards?

Again I don't want to mix up the terms, so correct me on the terms, but the Federal standards against which they are checking? Have you done that kind of survey?

Mr. Levy. Yes, sir; we have a compilation of the various State licensing requirements. While I couldn't relate to a specific State in terms of which one is higher or lower, as a general observation, the State licensing requirements go more to physical plant and safety factors, as opposed to the more health related items.

The medicare conditions are more comprehensive in terms of covering both the health-related items and the physical plant.

Mr. Brown. I don't want to monopolize this, Mr. Chairman, but I would like to pursue that point.

In Hill-Burton, for instance, to get Hill-Burton funds for a general line hospital, there are Federal standards, are there not? Now, how are the Hill-Burton standards measured, and how do they stack up against the State standards for health care in general hospitals?

Mr. Levy. Mr. Brown, I think it would apply equally well to extended care facilities and I happen to have the medicare extended care facility conditions with me.

In terms of physical plant, these conditions provide that the facility must meet the Hill-Burton standards if constructed with Hill-Burton funds. The medicare conditions say if it doesn't meet the Hill-Burton requirements, the medicare conditions would apply.

Mr. Brown. And they are lower than Hill-Burton requirements?

Mr. Levy. I really couldn't answer, sir, in terms of item by item. I would answer this way, that of course the Hill-Burton requirements apply to new construction. Now, in developing——

Mr. Brown. Or additions?

Mr. Levy. Or additions.

In developing the medicare conditions, the people who developed these had to take into account the fact that these were going to be applied to some older facilities as well as new facilities coming into the program.

So it might be quite possible that in some areas, recognizing, for example, what the building codes were in the past, that there might be more flexibility in the medicare conditions than in the Hill-Burton requirements.

Mr. Brown. The Hill-Burton requirements are generally stiffer than the State requirements are across the Nation, or are they not? In the safety area?

Mr. Levy. I would have to look at the applicable State requirements, State by State, sir, and compare it against the Hill-Burton requirements.

The State requirements do vary considerably from State to State. I know I am not responsive to your question as I would like to be, but I couldn't make a blanket statement.

Mr. BROWN. Well, I think you are responsive to this extent, if I may, and I recognize that this is a new area, and all of that. But it seems to me that some conscious thought should be given to a relationship between medicare assistance and Hill-Burton funding as relates to general hospitals and as relates to extended care facilities.

Now one of the things that just is a fact about this business that we are in of Federal assistance to State and local governments, is that when they get the Federal money, the Federal Government starts telling them what to do and what the standards have to be. In some cases, obviously, the State standards are higher than the Federal Government sets and so forth.

But nevertheless, where the money goes, there goes the control. The guy that pays the piper calls the tune. So in this case it would seem to me that it might be helpful to you in doing your job with reference to medicare funds and the approval of medicare facilities, to try to relate the job you are doing in some way to Hill-Burton. I am not suggesting that to receive Hill-Burton funds should be the criteria by which you determine whether or not a facility should receive assistance for the care of medicare patients, because that is a little, perhaps sets a standard a little higher than we might want to set it under the circumstances which you described, which I think are to a degree reasonable, in view of the fact that this program started very suddenly and you had to accept some facilities which may not be altogether desirable, or as desirable as new Hill-Burton construction.

I would like to raise one other question, if I may, or make an observation and get a comment on it. It seems to me when you have new construction in the "H" construction arrangements for a general hospital, where the nurses' station is in the center of this, or really what I am talking about is a square with legs, which is built not unlike the Rayburn Building, where the center of the building becomes the nurses' station—I realize I prejudice my argument even mentioning the Rayburn Building—but where you have that central nurses' station with the rooms around it, and then the rooms may be at the end where people who need less constant attention are located a little further away from the nurses' station, you have a different need for nurses than where you have the nurses stationed in a center of a corridor and the corridor goes both ways and the nurse has to run up and down the corridor to watch the patients all night. So I can understand how you can't set a standard for the number of patients per nurse.

But it seems to me when we get into the safety standards area—of course, Ohio had a grim experience in this recently—that the effort ought to be made to relate those safety standards to the Hill-Burton kind of standards with a view to the modification necessary because of the medical need for beds brought on by the onset of this program.

That is a lot to ask for a comment on, but let me say one other thing. That is that I personally subscribe to the Hinshaw approach in these things if you have adequate State standards. But it seems to me you have to look at those State standards for the guidance of this committee, or better said, the Ways and Means Committee, where this legislation basically springs from, in order to determine whether or not you can legitimately accept the State evaluation on these matters and feel that they have done an acceptable job with reference to the Federal Government standards.

Mr. TIERNEY. May I just comment, Mr. Brown, because I think you have made some extremely pertinent points.

I think there is one facet of the certification procedure we haven't made clear and that is the law specifically specifies that where a hospital is accredited by the Joint Commission on Accreditation of Hospitals, it automatically qualifies for participation in the program with only the further requirement at the time that it have a utilization review committee.

Mr. BROWN. Which in a way of saying means the Federal Government has accepted these private accredication agencies as a nonpareil in the field. Is that right?

Mr. TIERNEY. That is specified in the law.

Mr. BROWN. That has been done in certain other laws unrelated to hospitals, but certain other laws related to State approval of facilities which receive Federal interest or Federal money.

One can argue as to whether or not it is appropriate only with the facts as to whether or not those standards are high enough to meet standards that we would feel ought to be accepted at the Federal level.

Mr. TIERNEY. Yes, sir. I only want to make clear one other point and that is that the State licensure requirements are not controlling, they may be minimal, they still have to meet the conditions of participation. The law also specifies that at the request of a State the Secretary may impose higher requirements for participation by providers of services in that State than in other States. I think I am correct in the statement that in the 3 years we have only had requests from two States to impose higher requirements and that had to do with who is qualified to be the supervisor of a home health agency.

Mr. LEVY. That is correct.

Mr. TIERNEY. So we feel, sir, in the overall, that our requirements do more than meet the level of State requirements.

Mr. BROWN. All right. Let me ask just a couple more questions in that area about the Ohio case.

Was the nursing home involved in Ohio a newly constructed facility?

Mr. LEVY. I believe it was constructed around 1965 or 1966.

Mr. BROWN. At the time of the beginning of the program or thereabouts?

Mr. LEVY. Yes, it would have been.

Mr. BROWN. It seems to me it would be sensible to apply to newly constructed facilities the more stringent requirements of the Hill-Burton program or at least something closer to the requirements for Hill-Burton with reference to safety standards. That does not have anything to do with the fact that it is a general hospital versus an extended care facility. Whether or not the person is bedfast because of age, versus bedfast because he is not well enough to get out of bed really does not make any difference.

But the facility, if new, could very well have had the requirements set that are set on new facilities, new construction, of general hospitals.

Is that illogical, do you think?

Mr. LEVY. No. In fact, if the facility was a Hill-Burton constructed facility or Hill-Burton furnished facility, it would have to meet the Hill-Burton safety standards.

Mr. BROWN. If it had been Hill-Burton, it would not have had that carpeting. Isn't that right?

Mr. Levy. Yes. I understand the present Hill-Burton standards—I don't know what it was at the time of the construction of the facility—but the present Hill-Burton standard calls for the application of a test which would have ruled out that carpeting.

Mr. Brown. Thank you.

Mr. Fountain. I have several more questions about the health standards before we get to the question of safety.

Is an extended care facility required to be in compliance with all of the conditions of participation in order to participate in the program?

Mr. Tierney. It must be either, Mr. Chairman, in full compliance with all of the conditions of participation or must be in substantial compliance and moving toward full compliance.

Now at a given point in time a given institution might have deficiencies in one or two of the actual conditions of participation but is in substantial compliance and is moving toward correcting the deficiencies. And the deficiencies do not result in any health or safety hazards. So we have institutions which are in substantial compliance but not full.

Mr. Fountain. What criteria, if any, do you have for defining what constitutes substantial compliance?

Mr. Tierney. Mr. Levy?

Mr. Levy. Mr. Chairman, what we did when we started out on the certification process, we had these conditions of participation which I have referred to and which contain approximately 400 individual items.

As I believe Mr. Tierney testified on Tuesday, the extended care facility program was a brand new program, at least the concept of an extended care facility was new. In this setting we realized that one could not expect, with something like several thousand nursing homes in the country, that a facility, or a large number of facilities, could meet each and every one of these 400 items.

So we established a concept of two levels of certification. One we said where a facility could meet all of the requirements in the law and meet each and every one of the requirements in the major areas of the conditions, this facility would be certified as being in full compliance.

What I am trying to convey is that of the 400 items, there might be a very small number of items which a given facility at the time of the survey did not meet but which in the judgment of the State health department was not a severe deficiency and was not a deficiency that adversely affected the health and safety of patients.

Mr. Fountain. You mean they actually list 400 items?

Mr. Levy. There are 400 items they actually look at, Mr. Chairman.

Now this type of facility was granted a certification of full compliance, or in the jargon we use it is a so-called "A" facility.

We also were aware that there were many facilities that would meet all of the requirements in the law and would meet the major areas that the conditions went to although they might not be able to meet some of the so-called subcategories of the conditions, but that these facilities were working toward the correction of the deficiencies in the categories or subcategories that they could not meet.

So this type of facility was given a certification of being in substantial compliance or as we use the term a so-called "B" type facility. I would point out for the benefit of the committee, sir, that before a

facility can be given a certification as being in substantial compliance as opposed to full compliance, the State health department must make a finding that there were no adverse health and safety factors present and that facility was working very diligently and hard to correct these deficiencies. Perhaps it would help if I gave an example of the type of deficiency we are talking about.

One of the requirements we have is there either has to be a fulltime dietitian heading the dietary department or if the facility is small, it could have a part-time dietitian come in on a consulting basis.

It may have been at the time of the survey that the surveyor's judgment was that the food being served in the facility met all of the requirements for nutrition and adequacy, but perhaps two months before the survey the part-time dietitian they were using left her job.

Now if the facility could demonstrate that they were seeking to secure the services of another dietitian and it was in the judgment of the State a matter of time before they could locate that person, that facility would be certified as being in substantial compliance with the medicare requirements.

Mr. FOUNTAIN. How many extended care facilities participate in the program?

Mr. LEVY. There were 4,786 as of January 1, 1970.

Mr. FOUNTAIN. How many are in full compliance and how many are in substantial compliance?

Mr. LEVY. As of the first of January, 1,387 were certified in full compliance and 3,399 were certified as in substantial compliance.

I might explain also, Mr. Chairman, that there is a movement between those that are in substantial compliance and those in full compliance.

In other words, a facility may meet all of the medicare requirements at the time of the survey and when the surveyor comes back the next time, that facility may have run into some problems and as a result the State agency lowers the certification to substantial compliance.

On the other hand, when a surveyor recertifies a facility that is certified originally in substantial compliance he may find that the facility has corrected all of the problems and that facility would be recertified as being in full compliance.

Mr. FOUNTAIN. Have you made a careful check of those 400 items to see whether any of them may be picayunish or unnecessary?

Mr. LEVY. We have, Mr. Chairman, been continuously evaluating these items.

We evaluate them by meeting regularly with the State health departments, with the people who are out interpreting and applying these items. We get their feedback and judgment. We talk with the Public Health Service who have a responsibility for giving us counsel on the development of these items.

As a result of this effort, we are now doing a rather comprehensive review of these conditions of participation.

For example, one of the requirements we presently have, and in retrospect it was a requirement that everybody who participated in the development of these items felt a good item and should be in here, was that each extended care facility have a separate examination room, where when the physician comes to the facility he would examine the

patient. And so the requirement was that you had to set aside a room for this purpose.

We found in a very large number of facilities that it was the judgment of both the administration of the facility and of the physicians using this facility that such a separate room was not necessary.

The physician preferred to examine the patient at the bedside.

We will take this into account in redrafting these requirements. And this is the type of item we are finding, sir.

Mr. FOUNTAIN. Mr. Naughton?

Mr. NAUGHTON. Do you have any specific criteria, Mr. Levy, which tell a State what can be considered substantial compliance and what should not be approved as being in substantial compliance?

For example, I don't think anyone would quarrel with the idea that you might go without a dietitian for a couple of months if the food is OK, but do you tell the States you can approve without a dietitian, but don't approve a fire hazard as being in substantial compliance?

Mr. LEVY. We issue, in addition to these regulations, we have what we call a State manual in which the States receive instructions covering all aspects of the survey process including how to go about evaluating and making these judgments as to what is substantial compliance, what is full compliance, and what is out of compliance.

Mr. NAUGHTON. Do you essentially leave it up to the States to make the decision with the advice they find in the manual?

Mr. LEVY. By the law it is a State responsibility. They must make a recommendation or certification to us as to whether this particular requirement is in compliance or is out of compliance.

We try to give them guidelines and assistance in making this judgment.

Basically, however, it is a State judgment to make.

Mr. TIERNEY. I think for the record it ought to be clear, Mr. Naughton, that where a severe fire safety or other health hazard exists there can be no substantial compliance. This is out of compliance.

Mr. NAUGHTON. We will get to that a little later, Mr. Tierney. But just to conclude this business of the qualifications of surveyors, you mentioned an inventory compiled from the questionnaires sent to State agencies of the qualifications of persons at the State agency level.

Mr. LEVY. Yes.

Mr. NAUGHTON. That does relate to the qualifications of persons working at the State level, not the local level, am I correct?

Mr. LEVY. This relates to the State health departments. Our agreements are with the State health departments.

Mr. NAUGHTON. How many States rely on local officials, if any, to make the detailed inspections?

Mr. LEVY. The only State, sir, that uses local officials is the State of California. And there the local officials, the use of local officials is confined to one county, which happens to be Los Angeles County, and this is in accord, as I understand it, with State law, which says that any county over a certain population, the county health department does the surveying.

Now having said that, I am reminded that in New York State, the New York City Health Department surveys extended care facilities in New York City and in Washington State county personnel are used. But as far as I know, these are the three exceptions.

Mr. NAUGHTON. I am sure some States probably have excellent programs and they have requirements that qualified people make inspections and they see they are enforced. Some States probably don't. For the purposes of medicare inspections, the surveyors who actually go into the extended care facilities, do you have mandatory requirements that the States are supposed to observe, or the localities, if they use local inspectors, with respect to the qualifications of the surveyors, or do you leave it up to the State agency?

Mr. LEVY. It is basically up to the State health department. As I mentioned, the people who do the surveys must be hired in accordance with the State civil service merit system requirements.

Mr. NAUGHTON. There is nothing in your regulations that would prohibit a State, if it wanted to do so, from hiring a former used car salesman or former clergyman?

Mr. LEVY. I would hope there would be a prohibition in the State regulations.

Mr. NAUGHTON. But there is none in yours?

Mr. LEVY. Essentially, no.

Mr. NAUGHTON. Don't you think it would be advisable to put it into your regulations since you think it is a good idea?

Mr. LEVY. I would respond in this way: I would want to know whether we can legally impose this requirement on the State government:

Mr. NAUGHTON. So, in the three and a half years, or a little over 3 years since the program has been going on, you have not inquired to see whether you legally could require that surveyors be qualified for the job they are doing, let alone impose such a requirement?

Mr. TIERNEY. Mr. Naughton, I believe there is a judgmental question——

Mr. NAUGHTON. No, I am asking yes or no, have you asked for a legal opinon whether or not you could impose these requirements? You indicated, Mr. Levy, that you are in doubt as to whether you could legally require that the surveyors be qualified.

Mr. LEVY. That is right. Of course, that presupposes, sir, that we could actually specify or we should specify the types to be employed. I might add this, we do——

Mr. NAUGHTON. You are getting a little ahead, Mr. Levy. You indicated you thought it would be a good idea to have requirements in all States to keep them from using people who did not have qualifications for the job to go out and pass on the safety and health conditions in medicare facilities.

I suggested to you it would not be a bad idea if you did it yourself. You indicated you don't know whether you could legally impose such a requirement.

Mr. LEVY. Yes.

Mr. NAUGHTON. You have never inquired in the 3 years of this program?

Mr. LEVY. No.

Mr. BROWN. Mr. Chairman, could I ask just one question?

Do you have any requirement in your regulations governing the staffing of the health care facilities covering food handlers and their health qualifications?

Mr. Levy. Yes, there are. In the medicare conditions there are, Mr. Brown.

Mr. Brown. In other words, something that would prohibit active TB cases from handling food?

Mr. Levy. Yes, sir. I can appreciate your concern, sir.

Mr. Fountain. What system do you have for checking to whatever extent may be necessary to determine whether or not the States are complying with their own merit system?

Mr. Levy. We do, Mr. Chairman, a regular review, what we call an administrative review, of each State agency. This is usually done on a 12- to 18-month basis.

At that time, one of the things we would look at is whether the State is in compliance with applicable State civil service and merit system rules and regulations in the hiring of personnel.

Mr. Fountain. You have already pointed out that you have safety standards, including those for fire safety. They are included in the section of the conditions of participation relating to physical environment, I believe.

Mr. Levy. Yes, sir.

Mr. Fountain. Are these provisions, although referred to as standards, really only guidelines to State agencies which make inspections, and not mandatory?

Mr. Levy. Mr. Chairman, when the so-called medicare conditions were developed, these conditions were developed, of course, in counsel with a wide-ranging group of individuals representing various organizations. Now, we tried, in developing those, to be as specific as we could at the time, recognizing, of course, this was done in 1965.

I think in looking at them one would say some are very specific and some do leave room for the applying of judgmental factors. I really, although I do not mean not to respond directly, I really could not say on a specific item, because I think it would be a judgment that individuals would perhaps differ on whether this is specific or whether these are guidelines.

We do say in the physical plant section, as I recall, that these are guidelines that should be used or applied.

Mr. Fountain. That is not a very good word for many of us who have heard that term guidelines before.

Mr. Levy. I am aware of that, sir.

Mr. Fountain. That particular provision—405.1134—reads as follows: "The extended care facility is constructed, equipped, and maintained to insure the safety of patients and provides a functional, sanitary, and comfortable environment. The following standards are guidelines to help State agencies to evaluate existing structures which do not meet Hill-Burton construction regulations in effect at the time of the survey, and to evaluate in all facilities those aspects of the physical environment not covered by such Hill-Burton regulations. They are to be applied to existing construction with discretion and in light of community need for service."

But it is not mandatory. Of course, you do have a right to terminate funds if the State does not comply with its merit system, do you not, if it does not meet your requirements?

Mr. Tierney. At any time, Mr. Chairman. I think this is significant. Any time we have evidence that this now-famous used car salesman

was used, we would certainly do something. We have no such evidence.

Mr. FOUNTAIN. I was going to ask Mr. Naughton. Do you have any evidence of any such situation?

Mr. NAUGHTON. No evidence. We had an unconfirmed report to that effect. And apparently there is nothing in the regulations to prevent it.

Mr. FOUNTAIN. Mr. Brown has already mentioned the disastrous fire which took the lives of 32 patients in a medicare-certified facility in Ohio last month. According to press reports this facility has been described as one of the best constructed facilities in the country with basic construction which was highly fire resistant.

Of course, it did not prevent the loss of lives of about 70 percent of the patients. It is my understanding that the type of rubber-backed carpet that was used in the facility has been said to be a principal cause of the heavy loss of life.

Would the provisions in your guidelines, Mr. Levy, with respect to the use of fire-resistant materials and furnishings, if applied by the responsible State agency, prohibit the use of the type of carpeting which was involved in the Ohio fire?

Mr. LEVY. Mr. Chairman, if the State and local fire regulations which the facility must meet would preclude the use of that carpeting, it, of course, should not have been in the facility or else the State health department should have advised us of that.

Now, the medicare conditions for the health and safety factors would provide this, that if the facility, as I mentioned to Mr. Brown, met the Hill-Burton conditions, it is my understanding the Hill-Burton conditions or requirements would preclude that type of carpeting.

Mr. FOUNTAIN. But not the medicare?

Mr. LEVY. By reference——

Mr. FOUNTAIN. Well, the facility was approved.

Mr. LEVY. That is right, sir.

Mr. FOUNTAIN. For medicare participation?

Mr. LEVY. That is correct, sir.

Mr. BROWN. But not built with Hill-Burton funds; is that the distinction we are drawing here?

Mr. LEVY. Yes.

Mr. BROWN. Had it been built, even though it is an extended care facility, with Hill-Burton funds——

Mr. LEVY. Then I assume the Hill-Burton people would check whether it met that requirement, sir.

Mr. FOUNTAIN. Mr. Naughton.

Mr. NAUGHTON. Mr. Levy, there is not any question in your mind, is there, that the medicare regulations in themselves and without reference to Hill-Burton, because most of these are not Hill-Burton facilities, do not prohibit the use of that type of carpet?

Mr. LEVY. Mr. Naughton, we have issued a directive to the State agencies indicating to them that carpeting that has a flame spread rating of more than 75, using the Steiner tunnel test, is a fire hazard. We have told the States that they should immediately notify all ECF's and non-JCAH hospitals that any carpeting installed thereafter must be within the safety limits of the tunnel tests. And we have also asked them to contact each facility and ask the facility whether it is carpeted

and if it is to submit to the State health department a written statement from the manufacturer, from an independent testing laboratory, that the carpet and the backing have been rated in accordance with the tunnel test. Where the facility furnishes information establishing that the carpeting has a flame spread rating of more than 75 or the facility is unable to furnish information on flame spread rating, we are asking the State agency to get with the facility and the State or local fire authority to take steps to correct the deficiency or protect the environment from fire hazard.

Mr. NAUGHTON. What is the date of that communication to the States?

Mr. LEVY. This went out on February 17.

Mr. NAUGHTON. So that was Tuesday of this week?

Mr. LEVY. Yes, sir.

Mr. TIERNEY. I think, Mr. Naughton, we should be totally frank with you in this discussion.

Mr. NAUGHTON. I would appreciate it. We would save a lot of time.

Mr. TIERNEY. From the beginning, on the citation of the law which I cited, we have contracted with the State agencies and have said that they must meet the conditions of participation plus all local fire and safety codes.

I do not think you can find in our conditions of participation, and I am sure do not find in many fire and safety codes—I am told even in the 1967 edition of Life Safety Code—provision for testing carpeting against this tunnel test. This carpeting that was in that tragic fire, as I understand it, Mr. Brown, would pass what is called the pill test. Under this procedure, you ignite a methanamine pill on the carpet, see how fast the flame spreads. But we did not have a specific provision that would incorporate and require of every facility in the Nation that it pass this tunnel test.

Mr. NAUGHTON. At the time this Ohio facility was built, the Hill-Burton standards would have precluded the use of this carpeting. There were no medicare standards at that time?

Mr. TIERNEY. I do not know whether the Hill-Burton requirements at that time would have precluded it.

Mr. NAUGHTON. At the time of the fire the Hill-Burton standards would have precluded the use of that type of carpet; at the time of the fire your standards would not have precluded the use of that carpet?

Mr. TIERNEY. Not unless the Ohio law precluded it.

Mr. BROWN. I think we have a point that ought to be made here, because it relates to Mr. Levy's responsibilities. Hill-Burton funds would not have permitted the hospital to build the addition, or acquire it, with this carpeting in it. But had the hospital gone out on its own and installed the carpeting, there would not be any prohibition through the use of Hill-Burton funds in that regard.

And this comes back to the quality of the standards set for continuing approval of the facility and the quality of the people who are making those evaluations, whether or not the facility is meeting the standards.

I would make one other observation, because I do not think it has been given sufficient emphasis. As this program began suddenly, you indicated you accepted facilities for medicare qualifications that might

not be acceptable in the future. I would hope that we could have some assurance out of the Social Security Administration in the approval of facilities that unless facilities are upgraded in the future, that the marginal facilities, those which you consider marginal now, would be phased out over the years ahead by an increasingly stringent standard that would bring the social security medicare standards up to the level of standards generally applied to general hospitals.

I am sure that will not be very popular. That statement will not be very popular with those people who operate the extended care facilities at this point. But I think we have to look seriously at the ability of the patient to withstand what could happen to him in a facility where he is located.

Mr. TIERNEY. Mr. Brown, I agree totally with you. And I think in behalf of the Social Security Administration I can give you that assurance. If you were to go out today, sir, and apply the tunnel test to every bit of carpeting in every health facility in this Nation, I do not know what the impact would be. I think we might find a great deal of carpeting that would not pass the test. But I nevertheless totally agree—it is too bad that it is in the wake of a tragic situation—and you have our assurance that the requirements will be more and more stringent in this regard.

Mr. BROWN. I assume this committee will continue to be interested in this problem over the years ahead and we will see how well that assurance is lived up to.

Mr. TIERNEY. I am beginning to get that message, sir.

Mr. FOUNTAIN. Mr. Levy or Mr. Tierney, has an investigation been made of the Ohio fire?

Mr. LEVY. Yes, sir.

Mr. FOUNTAIN. When was it made?

Mr. LEVY. I believe there was a State investigation shortly thereafter.

Mr. FOUNTAIN. Have you made one?

Mr. LEVY. We have asked the health insurance regional office that has responsibility for the State of Ohio as well as the State of Ohio Health Department to give us a report. And we have also had a representative of my staff out in Ohio to personally meet with the Ohio State Health Department people about the fire.

Mr. FOUNTAIN. Do you feel that the investigation you are now making through these channels will be extensive enough?

Mr. LEVY. Yes, sir.

Mr. FOUNTAIN. Is it true that the last survey report on the Ohio nursing home showed the home to be in substantial compliance with correctable deficiencies, and one of these deficiencies was the lack of a sprinkler system in hazardous areas?

Mr. LEVY. The most recent survey report in March 1969, indicated lack of sprinklers in hazardous areas. It did not indicate what specific areas were deemed hazardous.

Mr. FOUNTAIN. How long had the home been certified under the medicare program without a sprinkler system?

Mr. LEVY. The home never had a sprinkler system. But I would add that given the type of construction for this home, it did not, under Ohio law, require a sprinkler system. In fact, I believe there is correspondence to the State from the architect at the time it was built

specifying, in response to an inquiry from the State health department, that given the type of construction a sprinkler system is not necessary.

Mr. FOUNTAIN. But they were in substantial compliance with the medicare guidelines, and they were in compliance with the State law?

Mr. LEVY. Yes, they did meet the State laws.

Mr. NAUGHTON. Of course, your guidelines did call for a sprinkler system in hazardous areas, did they not?

Mr. LEVY. Mr. Naughton, the guidelines call for sprinkler systems in hazardous areas unless there are other means of protecting the areas. This is also in accord with the applicable provision of Life Safety Code.

What they are really saying in the code and what we are saying is that if you have let's say a boilerroom, and if the area encompassing that boilerroom meets appropriate fire safety standards, you do not have to have sprinklers.

In other words, if you have say a 1-foot block wall around it, sprinklers would not be necessary.

Mr. NAUGHTON. That is the Life Safety Code you are speaking of? But the lack of a sprinkler system was cited as a deficiency, was it not, in your latest survey report?

Mr. LEVY. Yes, sir.

Mr. NAUGHTON. And that had existed since November 1966 when the facility was approved for the medicare program?

Mr. LEVY. I believe, as I recall reviewing the survey report, it was cited just in the 1968 and 1969 report.

Mr. NAUGHTON. Whether it was cited on the earlier reports or not, there never was a sprinkler system?

Mr. LEVY. You are correct, sir.

Mr. TIERNEY. Again for purposes of the record I think it should be made clear that this is a form which people go down and they fill in either yes or no.

It says "Is there a sprinkler system?" The answer is "No." But the requirement is that there be a sprinkler system in hazardous areas. It was the decision of the State and local health departments, as well as the documentation by the architect, that there were no hazardous areas in this particular home requiring a sprinkler system.

So it was not a case of there being a requirement for a sprinkler system and they did not have one and we nevertheless certified them.

Mr. NAUGHTON. I think we have established that you don't really have any requirements, you have guidelines. And I think what happens is you leave it up to the State.

Mr. TIERNEY. We have gone over the provisions of the Life Safety Code. It says you will have sprinklers where there are hazardous areas.

Mr. FOUNTAIN. I wonder if we have sprinklers in this building.

Mr. TIERNEY. It is a hazardous area only for some people. It depends on which side of the table you are on.

Mr. FOUNTAIN. Of the approximate 3,400 facilities which have been certified for medicare without being in full compliance, how many have deficiencies in fire safety?

Mr. LEVY. I would have to submit that for the record. I would be happy to, Mr. Chairman.

(The following statement was provided by Mr. Levy:)

NUMBER OF EXTENDED CARE FACILITIES WITH SAFETY DEFICIENCIES

Analysis of provider data in the central office of the Bureau of Health Insurance indicates that the data are insufficient for preparing a reliable statement on the incidence of patient safety deficiencies in extended care facilities. One of the reasons for this is that the survey information available in central office is received only after a lag of several months after the actual survey of the facility, a period in which many of the deficiencies noted at the time of the survey would have been corrected.

Because comprehensive survey records are maintained by the State health departments, who are responsible for making certification recommendations, we are working through the State agencies to identify and evaluate any existing safety problems which have gone uncorrected. The State health departments are being requested to report to the Bureau of Health Insurance for each facility any uncorrected safety problems, the circumstances surrounding them, and the steps being taken to resolve the problems.

(Since the statement supplied did not contain the requested information, further data was requested and the following additional material was then provided:)

DDEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., May 4, 1970.

Mr. JAMES NAUGHTON,
Counsel for Intergovernmental Relations Subcommittee,
Washington, D.C.

DEAR MR. NAUGHTON: Enclosed is information on extended care facilities with physical environment fire safety deficiencies as requested in your recent telephone conversation with Mr. Robert Mayne.

The Bureau of Health Insurance identified extended care facilities having deficiencies reported on the last State agency survey report form in the areas of physical environment or disaster plan. The deficiencies ranged from failure to have fire regulations posted properly, to an absence of automatic extinguishing equipment in appropriate areas. A listing of the deficiencies found in central office records is enclosed.

While the last survey report forms in central office were the source of the enclosed data, the information ranged from current survey reports (surveys accomplished within the last few months) to reports of surveys done a year ago. In addition, because of processing lags our files did not contain information for a number of facilities on the extent to which deficiencies have been corrected. (It is routine and in accordance with issued instructions for the State agencies to require correction of deficiencies and to so notify the facility after survey.)

Because our records are not yet complete on whether or not the deficiencies have been corrected, we have asked all State agencies to review their records, require correction of any deficiencies still outstanding, and report the results to us. Please let me know if I can be of further assistance.

Sincerely yours,

THOMAS M. TIERNEY,
Bureau of Health Insurance.

EXTENDED CARE FACILITIES WITH PHYSICAL ENVIRONMENT FIRE SAFETY DEFICIENCIES[1]

State	Number of facilities with fire safety deficiencies	Lack of automatic fire extinguishing equipment in all areas considered potentially hazardous	Inadequate exits or absence of secured handrails in all corridors	Stairwells not wide enough or free of obstructions	Doorways not wide enough	1 or more vertical shafts do not have closed fire doors	Lack of elevators or inadequate elevators in multistoried facility	Blind and nonambulatory patients above street level in nonfire-resistive buildings	Fire regulations not properly posted	Insufficient number of fire extinguishers	Fire drill, not conducted on all shifts 3 times a year	Hot water in some patient rooms may exceed 110° F.
Region I:												
Connecticut	39	6	6	1	2	2	30	1			6	3
Maine	8						1		1	1	7	
Massachusetts	31	1	1				16		1		20	1
New Hampshire	2		1						1		1	1
Rhode Island (N)												
Rhode Island (NM)	0											
Vermont	1	1										
Region II:												
Delaware	1	1										
New Jersey	13	4	1	1		3	2		3		7	
New York	113	67	26	10	1	26	45	24	18	21	28	6
Region III:												
District of Columbia	0											
Kentucky	7	4	2			2						
Maryland	2	1	1				2					
Pennsylvania	48	46	1				29		2		5	
Puerto Rico	2								2		2	
Virginia	17	7	3	1		1			2	3	8	
Virgin Islands												
West Virginia	0											
Region IV:												
Alabama	11	10									2	
Florida	40	14	11		13	29			1	1	10	
Georgia	13	3					2		1		11	
Mississippi	17	16				1			2	5	8	
North Carolina	24	22				2			2	3	5	
South Carolina	7	4								1	2	
Tennessee	4	3									3	

Region V:												
Illinois	18	15	1				2				5	
Indiana	20	13	1	1		1	1		1		8	
Michigan	34	6	6			11	6		5	3	13	
Ohio	91	71					9		8		33	
Wisconsin	34	19	2	10	4	10	1	5	5	2	20	
Region VI:												
Iowa	4	1	3		1						4	
Kansas	7	6	2			1					3	
Minnesota	15	7							1		10	
Missouri	2	1									2	
Nebraska	4	3									3	
North Dakota	1	1									1	
South Dakota	7	7									5	
Region VII:												
Arkansas	4	3				1						
Louisiana	7		1						1		6	
New Mexico	1						1				1	
Oklahoma	3	2							1		1	
Texas	70	39	2			18			1		20	
Region VIII:												
Colorado	18	8	4	1		2			3	2	5	1
Idaho	7	4	4			2	1		1	1	2	
Montana	3	2									1	
Utah	2	1	1									
Wyoming	4	1	2			2					1	
Region IX:												
Alaska	6	2	1		2				1		2	
American Samoa												
Arizona	3	3				1						
Califronia	73	35	27			4			1	1	34	5
Guam												
Hawaii	2	1		1							1	
Nevada	1										1	
Oregon	6	3	2								4	
Washington	39	34	8		2	5	4	1	5	4	18	2
National total	886	498	120	26	25	124	152	31	70	48	329	19

[1] Each column on the listing contains the number of facilities in the respective State with the deficiency described in the columnar heading. However, for each State, the sum of facilities horizontally does not total the number of facilities shown in the 1st column with fire safety deficiencies since some of the facilities in col. (1) contain more than 1 deficiency.

Mr. Fountain. We have some information which was compiled by the Community Health Service of the Public Health Service which indicates that as of January 1969 there were 1,660 facilities which had major deficiencies in their physical environment. Fire safety is included in physical environment, along with other factors, such as requirements for hand rails, ramps, and so forth.

But I guess it is likely that no one really knows exactly how many medicare certified facilities have major deficiencies in fire safety.

Mr. Naughton. You don't have that information?

Mr. Levy. I don't have it with me.

Mr. Tierney. We can certainly go through the record and get it.

Mr. Naughton. Is it available anywhere in the Social Security Administration at the present time?

Mr. Fountain. We are not encouraging any more redtape unless it is absolutely necessary because we are all overburdened with paperwork.

Mr. Tierney. We have a file on every single participating provider institution. It would require going through those. But I think it would be well worth going through those and seeing whether or not, as you are suggesting, there may be in those files a certification where it says there is a fire or safety hazard.

Mr. Fountain. Whether or not what you might find would justify the time and effort, I don't know, but that is a decision you can make as to how much time it would take to check into that sort of thing.

Mr. Tierney. I think it is a decision we will make, sir.

Mr. Naughton. You have not actually changed your guidelines or standards with respect to carpet?

You are trying to find out how many of the facilities have the same type of carpets. But you have made no change in your requirements that would prohibit it if you do find it?

Mr. Tierney. We have made this change. There will be no further carpeting installed in any facility that does not meet this test.

In the meantime, in all of the institutions in the Nation, the State health departments will go out and find out in those institutions whether there is carpeting or not, whether it does meet the test, and report back. I think that is in keeping with what Mr. Brown said. I think the worst possible thing we could do is issue a regulation and then not enforce it. And I think it behooves us to find out the scope of the problem and then issue a regulation.

It would be a simple thing to put out today a statement saying that every institution in this Nation will rip out its carpeting tomorrow unless it meets this code.

Mr. Fountain. Don't do that, we would hear about that in a hurry.

Mr. Naughton. Mr. Tierney, after all of the things you have described as difficult during the course of these hearings, I am amazed to hear you describe that as simple.

Mr. Tierney. It is simple to write a letter, Mr. Naughton.

Mr. Naughton. Have you actually changed the regulations to prevent installation of this carpeting?

Mr. Tierney. We have advised all State agencies the proposed regulation is being prepared for publication in the Federal Register with the 30-day comment period and I am sure there will be a great deal of comment.

Mr. NAUGHTON. So that part is not actually in force, although hopefully nobody will be putting that type of carpeting in?

Mr. TIERNEY. Well, it is in force as far as anybody from this day forward going out and installing new carpeting. We have told the State agencies we won't allow it. And not to certify them.

Mr. NAUGHTON. In other words, the crux comes when they try to get it approved after having installed the carpet.

Mr. TIERNEY. There is always a point in time; yes, Mr. Naughton.

Mr. FOUNTAIN. Do you know of any other facilities that have this same type of carpet now?

Mr. TIERNEY. No, sir. That is what we are trying to find out.

Mr. NAUGHTON. Mr. Chairman, on another matter, I have a letter from Mr. Tierney relating to this question of the delivery rooms and I think it might be advantageous if we put that in the record along with the opinion of the Office of General Counsel on that subject.

Mr. FOUNTAIN. If there is no objection, they will become a part of the record at the proper point.

(The letter and opinion follow:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 20, 1969.

Mr. JAMES R. NAUGHTON,
Counsel, Intergovernmental Relations Subcommittee,
Washington, D.C.

DEAR MR. NAUGHTON: You have asked why this Administration has not excluded the delivery room specifically as an ancillary service in modifying its cost report to reflect the 1967 Social Security Amendments and the involvement of titles V and XIX.

In developing its original cost report the program was aware that the delivery room in the average hospital is an integral part of the Ob-Gyn service and a part of the total cost of operating the institution. For this reason, delivery room as an ancillary service was reflected on the original cost report. Since there were only limited or no charges made to medicare beneficiaries for delivery room care, except as an incident to gynecological services, the RCC formula precluded a significant assumption of those costs.

Subsequently, in commenting on a problem concerning cost differential between the departmental and combination methods of apportionment, our Office of General Counsel advised that in its opinion delivery room as an ancillary service should not be included in the hospital's cost figures at all since medicare patients do not share in these services.

On the basis of this opinion, the program with the assistance of the Blue Cross Association and representatives from several Blue Cross plans developed a proposed intermediary letter to eliminate from routine care the higher cost related to private accommodations and to exclude from ancillary services the costs of those services in which medicare beneficiaries do not share. While developing the intermediary letter, we were advised by our intermediary representatives that the approach to the problem was not fair to the hospital because it did not consider all elements of cost. For example, nursing costs are incurred to a greater degree by the elderly than by the nonelderly. The intermediary letter could not deal with the problem because there is no practicable method which can be used to measure with any degree of accuracy the proper impact of these costs.

Other representatives in the hospital field also stated that the method by which the program would determine the routine care cost differential by type of accommodation would require inordinate additional recordkeeping for these hospitals.

While we were considering alternate approaches to the problem, the Secretary decided to disallow the percentage permitted as allowance in lieu of recognition of other costs. In view of this action, and recognizing that the method devised

was not wholly satisfactory, the Administration decided against further action at this time.

There is evidence that nursing costs for elderly patients are higher than for the nonelderly. Our problem is that we have not been able to develop a method which would determine the degree of variation in the light of each institution's actual experience. Since we have not satisfied the concern of the hospitals that the program is not paying its full share of nursing costs, we feel it is inappropriate, especially in light of the Secretary's action, to impose a policy which would result in further reducing the program's share of the hospital's costs.

You are no doubt aware that the Administration is committed to a reconsideration of its reimbursement principles to assure that the program is assuming its proper share of hospital costs. In this evaluation we intend to consider the problem of a proper allocation of nursing costs and to also clarify the treatment which should be accorded ancillary services, including delivery room, which are not utilized by medicare beneficiaries.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

NOVEMBER 7, 1967.

MEMORANDUM FROM OFFICE OF THE GENERAL COUNSEL

To: Mr. Raymond Del Rosso, Deputy Asst. Bureau Director, Division of Reimbursement, BHI.
From: Melvin Blumenthal, Assistant General Counsel.
Subject: Substantial variations in medicarecost reimbursement formulas—New York City hospitals (your memorandum dated October 13, 1967).

This is in reply to your memorandum dated October 13, 1967, in which you transmitted comments made by the New York City Blue Cross Plan along with materials from your files relating to substantial variations in cost reimbursement of New York City hospitals, depending upon whether the combination method or departmental method of reimbursement was employed.

We have reviewed the materials submitted and we agree that the New York City Blue Cross Plan is properly concerned about the possibility of substantial over-reimbursement of certain New York hospitals under the combination method of cost reimbursement. We do not agree, however, that there is any conflict between the principles of reimbursement for provider costs (Regs. Sec. 405.401 through 405.454) and section 1861(v) of title XVIII.

The comments of the New York City Blue Cross Plan and also the supporting material which you submitted indicate that there are two possible errors which could result in substantal over-reimbursement under the combination method:

(1) The inclusion of the cost of delivery rooms in the formula for computing the cost of ancillary services rendered to beneficiaries;

(2) The failure to reduce the average per diem costs for routine services (room and board, etc.) to take into account the fact that such costs may include the cost of private rooms furnished for the convenience of the beneficary.

I. COST OF DELIVERY ROOMS NOT ALLOWABLE

With respect to the first point, we note that in the four inpatient cost settlement sheets which you submited, the costs of delivery rooms *were* included in the reimbursement formulas and that consequently the amounts calculated under the combination method substantially exceeded the amounts calculated under the departmental method. We believe that the inclusion of delivery room costs in the reimbursement formula is clearly in error for the reason that such costs are in no way related to the cost of services furnished to beneficiaries, and hence cannot, under the provider cost reimbursement regulations, be charged or apportioned to the title XVIII program. In this connection regulations section 405.402(a) sets forth the basic rule that the program's share of institutional costs must be related to care furnished to program beneficiaries:

"405.402(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an

institution in the production of services, including normal standby costs, are recognized. *Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries* so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution." (Emphasis supplied.)

The objective of this rule is stated in section 405.402(b)(3) as follows:

"(3) *That there be a division of the allowable costs* between the beneficiaries of this program and the other patients of the provider *that takes account of the actual use of services by the beneficiaries* of this program and that is fair to each provider individually." (Emphasis supplied.)

Furthermore, there is a clear recognition in the regulations dealing with the apportionment of allowable costs that medicare beneficiaries are *not* a cross section of the total population and that the use of services by the over age 65 group differs significantly from other groups. As stated in section 405.403(c):

"(c) A basic factor bearing upon apportionment of costs is that title XVIII beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. *Consequently*, the objective sought in the determination of the title XVIII share of a provider's total costs means that *the methods used for apportionment must take into account the differences* in the amount of services reecived by patients who are beneficiaries and other patients served by the provider." (Emphasis supplied.)

See also section 405.403(f) which states, in pertinent part:

"* * * Consequently, consideration of equity among institutions are involved as well as that of effectiveness of the apportionment method under the program in accomplishing *the objective of paying each provider fully, but only, for services to beneficiaries.*" (Emphasis supplied.)

Thus the regulations require that provider costs be apportioned so that the program pays only for services that are actually rendered to beneficiaries. In the context of a program limited to beneficiaries who are over age 65, the cost of delivery room services are not allowable costs and hence may not be charged to the program regardless of which method of apportionment is chosen by the provider.

Under the departmental method of apportionment the cost of delivery rooms may not be charged against the program because medicare beneficiaries do not use the facilities in question. The same is true with respect to the combination method of apportionment. See in this connection section 405.404(a) of the regulations relating to methods of apportionment under title XVIII. Whatever method of apportionment is used only a provider's allowable costs may be taken into consideration, a point that is communicated in section 405.404(c) which states:

"(c) The second alternative is a combination method. Under this method, as applied to inpatient care, that part of a provider's total *allowable cost* which is attributable to routine services (room, board, nursing service) is to be apportioned on the basis of the relative number of patient days for beneficiaries and for other patients; i.e., an average cost per diem basis. *The residual part of the provider's allowable cost*, attributable to nonroutine or ancillary services, is to be apportioned on the basis of the beneficiaries' share of the total charges to patients by the provider for nonroutine or ancillary services. The amounts computed to be the program's share of the *two parts of the provider's allowable costs* are then combined in determining the amount of reimbursement under the program. Use of the combination method will necessitate cost finding to determine the division of the provider's *total allowable costs* into the two parts, although it would be less involved than for the first alternative, the department-by-department method." (Emphasis supplied.)

Furthermore, there is nothing in the portion of the regulations dealing with the methodology of apportionment which remotely suggests that the cost of delivery rooms may be allocated to the medicare program. Principle 2–2 (regulations section 405.452(a)), restates the basic rule of section 405.402(a) that the program's share of provider costs is based upon actual services to program beneficiaries:

"405.452 (a) *Principle.*—Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that *the share borne by the program is based upon actual services received by program beneficiaries.* To accomplish this apportionment, the provider shall have the option of either of the two following methods: * * *" (Emphasis supplied.)

Furthermore, throughout section 405.452 there are repeated references to the allocation of *allowable* costs with the repeated injunction that regardless of which method of apportionment is used, the objective is to approximate as closely as practicable the actual cost of services rendered to beneficiaries. See especially section 404.452(c)(1) which states, in part:

"(ii) The cost of services to beneficiaries of the health insurance program may be determined by either of the alternative methods, that is selected by a provider; however, the objective of whatever method of apportionment is used will be to approximate as closely as practicable the actual cost of services rendered.

"(iii) The two methods of apportionment available for use in determining the cost of services rendered to beneficiaries of the program have as their goal the allocation of the total allowable costs between the beneficiaries and other patients in as equitable a manner as possible * * * "

II. PRIVATE ACCOMMODATIONS

With regard to the second point raised by the New York City Blue Cross Plan, we agree that if the average per diem cost of routine services includes any amount attributable to the cost of private accommodations that were not required for medical reasons (section 1861(v)(2)), then such per diem cost must be adjusted downward. In this connection, the provider cost reimubrsement regulations permit payment only for the cost of covered services and require suitable retroactive adjustments at the end of each accounting period; as stated in section 405.451(a):

"405.451(a) *Principle.*—All payments to providers of services must be based on the 'reasonable cost' of services *covered under title XVIII of the Act* and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost." (Emphasis supplied.)

and in section 405.454(f)(1):

"405.454(f)(1) *Retroactive adjustment.*—(1) * * * Actual cost reimbursement to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services rendered to program beneficiaries during that period. * * *"

Although the provider cost reimbursement regulations do not specifically refer to the cost of private accommodations which are not required for medical reasons, this point is specifically covered both in the statute (section 1861(v)(2)(A) and in the Subpart A regulations. See in this connection, section 405.116(b) of the regulations wherein it is stated:

"(b) * * * The reasonable cost of private accommodations is covered in full only where their use is medically indicated, ordinarily only when a patient's condition requires him to be isolated. Where private accommodations are furnished for a patient's comfort, the amount payable under this Subpart A may not exceed the reasonable cost of accommodations containing from two to four beds. * * *"

Thus it is clear that the cost of private accommodations not medically required are not allowable under the program so that any payment to a provider which includes such costs must be adjusted to reflect actual program liability.

MELVIN BLUMENTHAL.

Mr. TIERNEY. Mr. Naughton, I hope you never find a delivery room with a carpet in it.

Mr. FOUNTAIN. Dr. Goldberg?

Dr. GOLDBERG. In connection with your new requirement that carpeting in extended care facilities meet the tunnel test, have you given any consideration to requiring that they also met the burning-pill test?

Mr. TIERNEY. It is my understanding that the tunnel test is a higher standard than the pill test.

Dr. Goldberg. No, it is a different kind of standard. One is not substitutable for the other. The pill test measures the flammability or the resistance to flame of the carpeting, and the other measures the rapidity and intensity of the flame spread. You could have a situation where carpeting is highly flammable, as many acrylics have been found to be in the past, and won't pass the pill test but which might pass the tunnel test, and vice versa. One is not a substitute for the other, and there is a great deal of argumentation among the experts who are concerned with setting standards in this area as to what is the most desirable standard.

I believe the Department of Commerce, which has the responsibility, not long ago published a notice in the Federal Register setting forth its finding that a new or amended standard may be needed for carpeting. I do not know whether Commerce contemplates a standard similar to the pill test, which, incidentally, GSA requires for any federally purchased carpeting. However, I think you might give some attention also to the question of whether you ought to expand your prohibition to carpeting which will not pass the pill test.

Mr. Tierney. I appreciate that, sir.

Mr. Fountain. Any other questions before I yield to Mr. Brown for a relevant observation?

Mr. Brown. I do want to ask one question, Mr. Chairman, that follows in this same area of thinking.

Is there still a need for additional extended care facilities to meet any backlog of need for this program? In other words, do we have people crying to get into extended care facilities where they are currently unavailable?

Mr. Tierney. Mr. Brown, the Public Health Service and we have made some surveys around the country.

As you would expect, there are areas which have some more than they need, and some areas which have, still have, a need for beds.

I am not aware of any area in which there is an acute need for expanded extended care facilities. One of the problems we discussed with the committee Tuesday is the concept of the extended care benefit as defined by the Congress, as an extension of the skilled continuous nursing service which one receives in a hospital, but doing it in a less expensive setting.

This is an area that requires a great deal of medical judgment. And there are assertions being made certainly by extended care facility administrators and organizations that the benefit pattern is so restricted that people are backing up in hospitals, and it ought to be broadened. This I think is something that we are going to be studying.

As I suggested to the chairman Tuesday, ultimately it will be a matter of Congressional determination of a social policy.

Do you want to really provide nursing home care or do you want to provide this concept of an extension of the skilled continuous nursing service of a hospital?

I think, and I am maybe reading your mail or suggestions made to you, but if you are getting suggestions today that people are unable to get into extended care facilities, it may be more over that factor than it is due to lack of the facilities themselves.

Mr. Brown. No, the reason I asked the question with reference to health and safety standards, was because it occurs to me that if there

is not a backlog of need for extended care facilities at present, except perhaps in spotty areas around the country where none have been built, and considering how profitable this business seems to have been and how much speculation there is in this field in the markets, I doubt that there are many areas of the country where this need has not been met and perhaps more than met.

It seems to me that you are in a position, if that is the case, to tighten up on health and safety standards. I for one just as a matter of observation as to how these programs work and how they become efficient and inefficient in their administration would suggest that you are perhaps on the right track using the State service or the services of State organizations if you are in a position to jack up those State organizations and assure that the services which they are providing in terms of checking are adequate.

If they are not adequate—and I am not sure we have really come down on one side or the other of that question in this discussion yet—if they are not adequate, then I suppose the issue becomes whether or not you set federal standards and try to enforce them with Federal inspectors.

In the long run I think we will find that adds to the cost of the whole operation for the economic cost, regardless of who pays it, will be higher if you have Federal inspectors than if you use existing State inspectors—even if you assure yourself they are qualified. (a) to inspect adequately, and (b) they are following stringent enough standards to assure safety with reference to Federal standards in this area.

I get the impression that our Federal standards are somewhat lower than the State standards in existing hospitals, but that is only an impression I get from this discussion. I don't know whether that is a fair assumption or not.

Mr. TIERNEY. I would hate to leave you with that impression, Mr. Brown, because I think the opposite is true in hospitals and extended care facilities.

Mr. BROWN. I am sorry, I don't want to leave you under a misapprehension, that the Federal standards for extended care facilities are lower than the State standards for hospitals.

Mr. TIERNEY. I am not sure I know what you mean, sir.

The standards for hospitals are for the most part established under the law as the standard of the Joint Commission on Accreditation of Hospitals.

The law further provides that if a State has higher requirements than the Federal requirements, they shall be imposed.

As I said before, we have only had two States—relative to home health agencies—impose higher requirements but only on one item of the home health agency conditions. So I don't think you can conclude that the States have higher requirements than we.

Mr. BROWN. For their hospitals as opposed to extended care facilities?

Mr. TIERNEY. For either one.

Now the standards for accreditation of hospitals of course, beyond fire and safety, go into a great deal more detail.

Mr. BROWN. I am speaking of only fire and safety, or health and safety.

Mr. TIERNEY. I think I understand it now.

Mr. FOUNTAIN. Before we recess, I would like to ask you one question: It is not relevant at this point, but do you take any kind of inventory or ask the States to take one to determine how many people stay in hospitals, how many unnecessary days, during an observation period or waiting for doctors to come and examine them or going through the routine things that they could go through by staying in a motel or staying in some other place?

Mr. TIERNEY. Yes, sir, we do, through a series of different approaches.

First of all, every hospital in order to participate again under mandate of the law must have a so-called utilization review committee. This is a committee of the staff, of the medical staff that reviews admissions, lengths of stay, and must review long-term stays on a continuing basis.

First of all, the State agency goes into an institution and determines that such a committee exists that the facility has a utilization review plan, and that the facility's committee is operating in accord with the plan. A committee can exist on paper and not be very effective. Thereafter the intermediary's role on a continuing basis is to evaluate the effectiveness of the utilization review being carried on in the institution.

We in turn through our program validation and our contract performance reviews look to see whether or not the intermediary is following up and making sure that utilization review is effective.

I am sure you appreciate, Mr. Chairman, that in the final analysis a person is in the hospital because a physician certifies he needs to be there and he continues to stay in the hospital because his physician continues to certify he needs to be there.

Now this review by a medical staff I think is an excellent thing. I don't know how we will ever be able to prove how effective it is in medicare, because we had it from the inception. If we operated for a while without it and then put it into effect, we might have seen a dramatic change. But it has always been a part of the picture.

I don't profess that it is an absolute guarantee that there aren't people unnecessarily in hospitals, but they are in hospital because the doctor certified they needed hospitalization and the Utilization Review Committee has not disagreed with the doctor.

Mr. FOUNTAIN. I guess this is an area where some work has to be done with and among doctors, because I have had some private physicians to tell me in their opinion millions of dollars could be saved if we could ever find a way to prevent that sort of thing from happening, that is unnecessary stay in the hospital, not just recuperating from an illness, but going in there and staying 5 or 6 days for routine examination and paying the regular hospital fee.

Dr. Goldberg?

Dr. GOLDBERG. Is it discretionary with each of the hospitals as to who serves on the Utilization Review Committee, or do you have any standards mandating certain procedures?

Mr. TIERNEY. There have to be at least two physicians from the medical staff on the committee and at the facility's discretion other qualified nurses or medical personnel. But we don't specify who those people will be, no.

Dr. Goldberg. The same doctors who might be placing people in hospitals unnecessarily or keeping them there for a longer period of time than is required for their medical conditions could be the same persons who are judging their own conduct.

Mr. Tierney. You are right, sir.

Mr. Fountain. The committee stands recessed subject to the call of the Chair.

(Whereupon, at 1:20 p.m., the committee was adjourned.)

ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(Part 1—Medicare Program)

TUESDAY, MARCH 3, 1970

HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10:15 a.m. in room 2203, Rayburn House Office Building, Hon. L. H. Fountain, chairman of the subcommittee, presiding.

Present: Representatives L. H. Fountain, Clarence J. Brown, and Guy Vander Jagt.

Staff members present: James R. Naughton, counsel, and Thomas H. Saunders, minority staff.

Mr. FOUNTAIN. The committee will come to order. The record will show that a quorum is present.

Our hearing today is a continuation of a series of hearings which we began last month concerning the administration of the medicare and medicaid programs. Our witnesses today will be Mr. Thomas M. Tierney, Director of the Bureau of Health Insurance, Social Security Administration, which administers the medicare program, and some of Mr. Tierney's associates in that Bureau.

During the hearings last month, most of our questions were addressed directly to Mr. Tierney. Since we will be getting into details of program operations this week, rather than some of the more general matters we discussed previously, I think it might be appropriate if we place a little less of a burden on Mr. Tierney and address our questions wherever feasible to the persons who have direct responsibility under Mr. Tierney for particular operations.

It is my expectation that most of our questions today will be directed to the use of intermediaries in carrying out the medicare operations, and the manner in which those intermediaries have been carrying out their responsibilities.

Mr. Tierney, before we begin our questioning, I wonder if you would identify the other witnesses with you?

Mr. TIERNEY. On my left, Mr. Chairman, Mr. Robert Mayne, who is the Assistant Bureau Director in charge of Intermediary Operations. On his left, Mr. Robert Ouloosian, who is Chief of the Contract Administration Section in that Division, and on my right is Mr. Wilson Jones, who is Chief of the Contract Financial Management Branch of that Division.

These are men who are obviously directly involved in the day-to-day operations and relationships with intermediaries.

Mr. FOUNTAIN. We are delighted to have all of you with us and appreciate your presence here this morning.

Mr. Mayne, I wonder if you would describe your responsibilities in the Bureau of Health Insurance.

Mr. MAYNE. I joined the Bureau of Health Insurance as a member of the predecessor task force that was established in February of 1965 before the legislation was passed. At the time we formed the Bureau, I was assistant to the Director, responsible for the development of an organization, of an administrative pattern and a rather broad range of involvements in the planning for getting started with the medicare program on July 1, 1966.

I went to the position of Assistant Director in charge of the Division of Intermediary Operations in November of 1967 and have been in that position since.

Mr. FOUNTAIN. Generally speaking, what part do intermediaries play in the administration of the medicare program?

Mr. MAYNE. The intermediary is the real key to the operation of the program. The statute and the contracts that we have with these intermediaries—the contracts are based on the statute—provide that the intermediaries will make determinations on payments that are required to providers on a reasonable cost basis: receive, disburse, and account for funds: audit records of the providers; and serve as a center for communication with the provider on the policies and instructions that are used to implement the program.

They have then other duties which are of less importance as far as overall responsibility is concerned, but they are still of considerable importance in that they are charged with assisting providers of service in the development of their abilities to effectively assure the employment of utilization safeguards, and they are to conduct studies to assess the application of utilization safeguards.

They are also to make management studies as may be necessary at the direction of the Secretary and participate in statistical research studies as may be required by the Secretary. They must have, because of their responsibility for processing claims, for making payment for the reasonable cost of the services rendered medicare beneficiaries, a procedure for reconsidering and hearing disputes involving providers. This is largely the role of intermediaries.

So the whole focus of the relationship is the provider to the intermediary and as you will recall in the session we had the other day, we identified the fact that the intermediary is nominated by groups or associations of providers, so the relationship is very clearly established.

Mr. FOUNTAIN. About how many different intermediaries are there and how are they classified?

Mr. MAYNE. We have a prime contract with the Blue Cross Association, which in turn has subcontracts with 74 Blue Cross plans.

In addition, we have prime contracts with nine other organizations, seven of which are commercial insurance companies. The other two are Intercounty Hospital Service which is not an insurance company, and then the Kaiser Foundation which is an intermediary for its own hospital.

Mr. FOUNTAIN. How many commercial insurance firms?

Mr. MAYNE. Seven commercial insurance firms, and two other intermediaries; using the term "commercial insurance" a little loosely. One of the seven is a cooperative in Puerto Rico. We classify them with the commercials. Then there is The Kaiser Foundation and Intercounty Hospital Service in Philadelphia. So there are nine in that group.

Mr. FOUNTAIN. Does the law require the Social Security Administration to accept any intermediary chosen by a provider, or does it permit Social Security Administration to reject an unsatisfactory intermediary?

Mr. MAYNE. No, sir, the statute provides that the Secretary is to accept these nominations but that he would not accept them if there was reason to show that there would not be effective administration, or that they could not serve to carry out the utilization safeguards as required by the statute.

So there are two factors there.

Mr. NAUGHTON. Mr. Mayne, as a matter of fact, section 1816(b) which relates to the selection of intermediaries and use of intermediaries, specifies that the Secretary shall not enter into an agreement with any agency or organization under this section unless he finds that to do so is consistent with the effect and efficient administration of the hospital insurance program, does it not?

Mr. MAYNE. That is right.

Mr. NAUGHTON. So there is a positive duty upon the Secretary not to accept any intermediary unless they are prepared to do an efficient and effective job.

Mr. FOUNTAIN. How many intermediaries handle the bulk of the medicare program?

Mr. MAYNE. Well, you have to look at the types of providers. As far as the hospitals are concerned, the Blue Cross system handles about 93 percent of all of the hospitals. With respect to the extended care facilities, the Blue Cross system handles 53 percent and the other intermediaries handle 47 percent.

Mr. FOUNTAIN. Can intermediaries be held financially responsible if the medicare program suffers losses because of gross negligence of the intermediary?

Mr. MAYNE. That is a very interesting question, Mr. Chairman. The statute provides that we are to pay the intermediary their administrative cost in administering the program. The only provision that is made for holding them liable is in the event that a certifying officer or disbursing officer working for an intermediary is found to be guilty of gross negligence or intent to defraud. We then have recourse. The language which is in 1816(e)(1) says that no individual designated pursuant to an agreement under this section as a certifying officer shall in the absence of gross negligence or intent to defraud the United States be liable with respect to any payments certified by him.

And then you have the same provision in subpart 2 with respect to a disbursing officer; and then subpart 3 nails this down by saying that no such agency or organization shall be liable to the United States for any payments referred to in paragraphs 1 and 2.

Mr. NAUGHTON. Mr. Mayne, is it your interpretation of that statute that if gross negligence on the part of a large insurance firm or large Blue Cross plan results in the unnecessary and unjustified expenditure and loss of a million dollars in taxpayers' funds, that you may be able to recover it from the clerk who made the payment, and signed the check, but you can't go against the insurance company?

Mr. MAYNE. Well, I would say we would surely try. We have not had a situation as yet where we were in the position to really press or to propose such an action.

Mr. NAUGHTON. Aren't you concerned that this provision of the law may prohibit you from recovering in the event you find that gross negligence by one of the organizations you are doing business with has cost you a lot of money?

Mr. MAYNE. Well, I think we would have to go with the record on that, Mr. Naughton, and see what the situation would be.

Mr. NAUGHTON. But you have never been concerned enough about it to ask your General Counsel for an expression of opinion on what your recourse is or possibly to recommend that the Congress change this provision of the law?

Mr. TIERNEY. I think we have discussed this—if I may, Mr. Chairman—general area of consideration with the General Counsel. We have discussed it with committees of the Congress.

As a matter of fact, the Senate Finance Committee staff report raises the question of whether or not it is feasible to ask these organizations, commercial insurance companies and Blue Cross plans, and on the part B side there are 33 Blue Shield plans and 16 commercial insurance companies involved, to operate this total administrative process on an absolutely no-gain, no-loss basis.

There is no room for them to make any money. They are paid their audited costs. Whether or not it is feasible to ask any organization to assume a risk of, say, a million dollars—it could be more than a million dollars—where you pay them absolutely nothing to undertake such an assumption of risk, is a very doubtful question.

So that I think this is something that probably is a policy determination that will ultimately be made.

If you are going to hold somebody responsible, which this law purports not to in the absence of gross negligence, I can't imagine the organization assuming that responsibility without being also compensated for some kind of a risk factor.

The Senate Finance Committee staff report suggests that that be built into the system, and so it is under consideration.

Mr. NAUGHTON. Well, if there is no gain to the commercial insurance firms or the Blue Cross plans for participating why do they do it?

Mr. TIERNEY. I think some of them are beginning to wonder why. I think in the early stages of the game, there are obvious reasons why they did it. This was the first large involvement of the Federal Government in the financing of health insurance in the Nation. There was great consternation in the private sector that this was the camel's nose under the tent, and the Federal Government would be moving in.

Both the providers of the service and the people in the private sector at that time felt it important to play a significant and meaningful role in the operation of medicare. The Congress made specific provision for it.

If you go back and read the congressional committee reports they were much stronger than the law itself that this was to be the mechanism, that it would be largely administered by private health insurance carriers of proven capacity and ability.

At that time therefore, they assumed that this was a role that was an appropriate one for them.

I said a minute ago—perhaps jocularly, but it didn't seem to get much of a laugh—that some of them are reevaluating their positions because they do find now that there is no profit, that what they might have felt was a good public relations thing to do is being questioned because they are being asked more and more and more to operate a stricter and stricter surveillance over the institutions that have nominated them, over the doctors to whom they are making payments, and I just would assume that some of them are beginning to wonder, in the absence of a payment of some kind, of a plus factor—and I don't like the use of those words—but the absence of a payment of some kind of an incentive for them to do an effective job, whether or not they want to continue the role indefinitely.

Mr. NAUGHTON. They are reimbursed, of course. The intent of the law is that they are to be reimbursed for all costs.

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Reasonable costs.

Mr. TIERNEY. And I think there are some advantages that may inure to some of them in the ability to allocate some portion of administrative overhead—perhaps a most significant area—an ability to provide a basic claims volume sufficient to utilize a larger computer capacity than they might out of their own business.

So that these are some intangible benefits. But they have to account for every penny they spend on medicare and that is what they get paid, and that is what is audited out and what is the end of it.

Mr. NAUGHTON. Of course, it gives them a chance to gain experience without any risk.

Mr. TIERNEY. Mr. Naughton, most of these companies have had long, long years of experience; that is why they were selected.

Mr. NAUGHTON. In a program similar to this?

Mr. TIERNEY. Not in a program of the broad spectrum of medicare, of home and office calls and all the things the voluntary private sector has traditionally not provided.

Mr. NAUGHTON. In view of your past association with Blue Cross, could you give us information on the background of the Blue Cross and Blue Shield organizations?

Mr. TIERNEY. Well, yes, sir; a very brief summary.

Blue Cross had its inception down in Baylor Hospital in Dallas, Tex., back in 1929, when a man named Dr. Justin Ford Kimball thought up a simple idea, and that was that a group of Dallas schoolteachers would pay 50 cents a month to this hospital, and the hospital would put the money in the cash drawer and when, as and if these schoolteachers needed hospital care, the hospital would make it available to them.

This was at a time when, as you know, the depression was hitting. Hospitals were faced with tremendous financial problems, and even though costs were only something like $3 or $4 a day, there were millions of Americans denied access to hospitals because they didn't have

that much money, and it was kind of an idea whose time had come.

During the 1930's independent autonomous voluntary Blue Cross plans sprang up in virtually every State in the Nation, with the exception of Nevada, where there still is not a program, and many States had five or six or seven, developed around counties or districts.

In 1939 doctors of California decided that hosptal insurance seemed to be catching on with the public, so Blue Shield was formed in an effort to provide a mechanism for the financing of medical services. The whole original scope of Blue Shield coverage was in-hospital medical and surgical care. It was felt that you could insure against surgical procedures because nobody wanted to undergo surgery, but if you broadened it out further than that, you couldn't make it an insurable thing.

I might say that the private health insurance sector had felt that the approach to this was indemnity. You pay out so many dollars per week in a hospital, or agree to pay a hundred dollars' worth of X-ray costs. The departure that the Blues brought into the field was paying for services rather than paying dollars.

They said: "We will cover the hospital bill." Well, nothing much happened during the 1940's, until 1948, when the automobile union negotiated and for the first time made health benefits a part of the bargaining table negotiations, and under the impetus of that, in 1948 Blue Cross and Blue Shield mushroomed.

They grew steadily through the fifties, and have continued to grow since. I have not seen the most recent figures, but I think the Blue Cross plans of the country cover some 68 million people, Blue Shield something less than that—maybe 60 million.

In 1957, the Blue Cross Association was formed, originally as a national enrollment entity to handle national accounts. It really became activated in 1960, and I suppose its first significant national account was the Federal employee program under which, as you know, Federal employees have a choice between a national Blue Cross-Blue Shield service plan, or an indemnity plan which is underwritten by Aetna.

The second big event for the Blue Cross Association was certainly its assumption of the role of prime contractor under medicare. Rather than the Secretary having contracts with the 74 separate Blue Cross plans around the Nation, he entered into a prime contract with BCA under the terms of which they agreed to supervise and give surveillance to the operations of the plans.

I don't know if you wanted that long-winded a history or not, Mr. Naughton.

Mr. NAUGHTON. I guess it won't hurt anything.

Mr. FOUNTAIN. It's good for the record to have this information.

Mr. NAUGHTON. What part, if any, did the American Hospital Association play in the growth of Blue Cross plans?

Mr. TIERNEY. Well, the American Hospital Association has had a long affiliation with Blue Cross. Blue Cross was the child of the hospitals. This is where it came from.

Before there was a Blue Cross Association, there was a Blue Cross Commission, and that was a commission of the board of trustees of the American Hospital Association, and that was the license authority, that was the organization that said to a local group of people in

Illinois or Iowa, all right, you set up an organization, nonprofit, which meets our criteria, and you are therefore licensed to use the Blue Cross symbol. The symbol still belongs to the American Hospital Association.

That commission was abolished, but there has long been a close affinity between Blue Cross and hospitals, because, as I said, while in later years certainly the thrust of the Blue Cross philosophy and influence has been directed more toward consumer cooperative identification, it nevertheless was from its inception a prepayment plan for hospital services sponsored by hospitals.

I think now you have a different market than you had in those days. Today Blue Cross competes with the commercials for General Motors business or steel business or something else on the basis of who can provide the benefits most efficiently and economically. Unlike the old days, whether or not you were nonprofit or whether or not you had associations with professional organizations, are factors that don't mean much any more.

Mr. NAUGHTON. Did the American Medical Association play a similar role in the establishment of the Blue Shield program?

Mr. TIERNEY. No, I don't think the American Medical Association did. As a matter of fact, it looked with some foreboding on the formation of Blue Cross and Blue Shield.

The AMA has endorsed voluntary third parties prepayment arrangements, but there is no direct affiliation between Blue Shield and AMA.

Mr. NAUGHTON. Is there a connection between Blue Cross and Blue Shield other than the fact they operate together, or are they independent?

Mr. TIERNEY. They are independent organizations and independent corporations in virtually every State. There are maybe one or two States where there is a single corporate entity, but for the most part they are separate corporations.

But they have traditionally shared common services—enrollment, billing of premiums, processing of claims and this sort of thing. Usually the Blue Shield organization has its own claims staff, its own professional relations staff, and Blue Cross has its separate staff.

But I think they have found it efficient and effective to avoid duplication of services, and in most places they operate together. This isn't true everywhere. In California, they are competitors. Blue Cross sells hospital and medical services, and Blue Shield does the same, and they fight for the business. The same is true in Minnesota and several other places, but I think the general pattern has been one of not affiliated, but cooperative corporate entities.

Mr. NAUGHTON. Is there any national organization that exerts the type of influence over the affairs of local Blue Shield plans that would perhaps be exerted by the American Hospital Association over the local Blue Cross plans?

Mr. TIERNEY. I'd like to go back—I don't know that you have established—or I hope I haven't established a belief that the American Hospital Association exerts influence over the local Blue Cross plan.

Mr. NAUGHTON. They control the symbol, if nothing else.

Mr. TIERNEY. Interestingly enough, the criteria are quite easy to meet. You must be nonprofit; you must pay out a percentage of

premium income in benefits; you cannot have directly salaried salesmen. As long as you do these things, there is no way to revoke the license.

So that isn't much of a weapon, Mr. Naughton. There isn't any Blue Shield organization exactly the equivalent of the BCA. The National Association of Blue Shield Plans has never been an operating entity to the extent that BCA has been. It does, however, as the national trade association, represent the Blue Shield plans of the country.

Mr. NAUGHTON. Apart from any auditing or other control that might be exercised under contract, does any Federal agency have any regulatory authority over the Blue Cross and the Blue Shield operations?

Mr. TIERNEY. I think in every State in the Nation, with the possible exception of Missouri which may now, all plans are under State insurance commission regulation. I believe in one State the regulating body is the State banking corporation. But they are all regulated as to benefits and rates.

Mr. NAUGHTON. Do the laws require that all of them be nonprofit?

Mr. TIERNEY. No; not the laws as such. Most States have enabling legislation for nonprofit organizations to be formed, and that is how most of these organizations were formed. But there is no law requiring any third party health program to be nonprofit.

Mr. NAUGHTON. To your knowledge, are there any Blue Cross plans that are operated on a for-profit basis?

Mr. TIERNEY. No; I think under a quirk of the law, the Indiana Blue Cross plan is organized as a mutual insurance company, but many people say this is the same thing as nonprofit. In other words, there are no stockholders. The members own it.

Mr. NAUGHTON. Do the laws generally limit or not limit the salaries that can be paid?

Mr. TIERNEY. I don't think the law limits the salaries that can be paid.

Mr. NAUGHTON. To your knowledge, do the maximum Blue Cross salaries exceed the Government salaries for the same level of responsibility?

Mr. TIERNEY. Yes; to my sad knowledge, this is true.

Mr. FOUNTAIN. Do the contractual relations between the Social Security Administration and Blue Cross differ from those of other intermediaries?

Mr. TIERNEY. Mr. Fountain, we have direct contracts with the commercial companies—Mutual of Omaha, Aetna, Travelers, the others. We deal directly with them, and even though they may operate in four or five States, we don't have a direct contract or subcontract with their local offices in four or five States.

With Blue Cross it was different. The Secretary did contract at that time directly with the Blue Cross Association, as the prime contractor, and then they entered into approved subcontracts with the local plans.

Now there are two differentials, Mr. Chairman, in the language of the contracts. The contract with the commercial companies says that the intermediary will comply with the regulations promulgated by the Secretary and the directives issued by him.

The Blue Cross Association contract says that BCA will comply with the regulations issued by the Secretary and BCA took the position

that as the prime contractor, it would receive directives from the Secretary, or from my Bureau, or from SSA, and it would transmit directives to the subcontracting plans.

The second thing was that in the other contracts it provides that the commercial intermediary will be a channel of communication between the Secretary and providers of service. In the Blue Cross contract, there is a provision that it will be the channel of communication between the Secretary and providers of service. This again, at the time, sir, had as its concept that they were going to centralize and control and direct all of these 74 plans around the country, and they would do the channeling of communications to the providers, rather than having us contacting directly the providers through each of the plans.

Now those don't seem like very significant differentials, but they have caused some problems in the operation of the program. These contracts run for a period of 2 years, and the current contracts will expire July 1 of this year. We gave notice to all intermediaries and carriers—the intermediaries as we must a year ago—that we didn't intend to renew the existing contracts and some of these things, Mr. Chairman, we will be clearing up in the new contracts.

Other than those things, there are no other distinctions.

Mr. FOUNTAIN. As I understand it, your contract with the national Blue Cross Association requires that communications with the local Blue Cross plans be routed through Chicago, rather than directly between Baltimore and the local plan, is that right?

Mr. TIERNEY. That is what the contract specified, and for quite a while that was a hangup. Frankly, the Blue Cross Association, Mr. Chairman, is quite zealous of its role. They felt they were in a position to more effectively coordinate the activities and get greater uniformity of performance from plans if they controlled the directive.

More recently, we have determined from a number of sources, in our review of operations, that it is impossible to keep on top of intermediary operations and carrier operations around the country even through our own regional offces, and we are now putting people on site in the major intermediary and carrier operations in the country, and hope to have people on site in all of them in another few months.

So that while these early niceties of contractual language have caused difficulties in the past, I think we have largely overcome them. Because we have people right in their offices now, to say nothing of going through Chicago.

Mr. FOUNTAIN. From your experience, taking into account the arguments you have made, have you found that dealing through Chicago creates an unnecessary layer of bureaucracy?

Mr. TIERNEY. Mr. Chairman, I think there are a lot of values to it. In the first place, one of the main things BCA does is provide a nationwide wire system which we fully utilize in the operation of the medicare program.

For every one who goes to the hospital, there is a query sent to Baltimore to determine whether or not he is eligible, whether or not he used up his spell of illness, whether or not he paid up his deductibles. A BCA wire system they had in effect before medicare started is used to communicate these requests and responses.

Mr. FOUNTAIN. That is done as soon as the person enters the hospital?

Mr. TIERNEY. Yes, sir. That is a great value. Blue Shield plans which are coordinated with the Blue Cross plans use that same wire system for the part B side, so this is a real value.

There is a real value in having some kind of a central point where you can get a uniform performance effort. Now of course Blue Cross is a much bigger thing, but I think it is similar in concept to dealing with, say, Aetna Insurance Co., rather than 14 different Aetna offices around the country.

To the extent, however, that it has developed any duplication of effort, and in the audit area I personally feel that the present procedure of having current audits go from the providers to the plan's auditor, to the plan, through BCA and then to us sets up a triple review which may be unwarranted.

These are things I think we can eliminate. But I would hate to see us wipe out the whole thing.

Mr. FOUNTAIN. Have you had any difficulty in obtaining appropriate information from local Blue Cross plans, or in getting them to understand and carry out requirements?

Mr. TIERNEY. I am sure we have had a lot of difficulty in getting a lot of people to understand and carry out the requirements, Mr. Chairman. I think what you are speaking of is getting information from local plans.

Again, early in the game, one of our regional offices wanted some information about what was going on in the local plan. BCA took the position that the information had to be obtained through their regional representative or through Chicago.

This sounds melodramatic, and sounds almost childish in some respects. I think for the most part, we have overcome it, Mr. Chairman. There are still instances when I would prefer to pick up a phone and talk to the guy in San Francisco and get an answer direct. On the other hand, I think they have to an extent a legitimate concern that the answer of the guy in San Francisco is the same one that the guy in Boston is going to give me.

Mr. FOUNTAIN. Mr. Naughton suggested I might ask you to comment on the same question, Mr. Mayne, since you are directly in charge.

Mr. MAYNE. I gathered from the question, Mr. Chairman, that there was an interest in identifying particular situations where the accumulation of information had been delayed.

Mr. FOUNTAIN. Right.

Mr. MAYNE. There have been situations where we have asked for information and it has not come in within the deadline we have asked for.

Mr. FOUNTAIN. What is your usual deadline, or does it depend upon the individual situation?

Mr. MAYNE. This would vary, depending on the kind of information we were seeking. In some of these situations, the delay was because of the BCA's recasting, and in some of these cases it was in collaboration with us—saying, we will be glad to go out and get this information for you. We think however it would be better if you asked it in this way, or add these particular things to it.

So this was done. Then BCA has had the problem of getting the information back in time from the plan and there have been instances when they have not met the deadline.

Mr. FOUNTAIN. Has that been true to any great extent?

Mr. MAYNE. I would say no, not to any great extent.

Mr. NAUGHTON. Do you feel that lack of availability of information that you requested has not been a serious problem?

Mr. MAYNE. I think, Mr. Naughton, it is a question of how readily available was the information, and what did they have to do to get it. If we are after information, we set a deadline, certainly we would hope to have it available at that time. But a program of this kind, you can't always make a judgment in Baltimore as to how readily information is going to be available. This is particularly true where you are relying on data that are accumulated in a plan. A great variety of systems are present in these individual plans, some with very sophisticated computer systems that can spill the information out very quickly; others that will have to accumulate it largely on a manual process.

Mr. FOUNTAIN. Incidentally, do you all do any checking behind the computers?

Mr. MAYNE. Absolutely.

Mr. TIERNEY. Computers can make some of the worst mistakes you can conceive of.

Mr. FOUNTAIN. I have been involved with some of them.

Mr. TIERNEY. When a computer makes a mistake, it is a whopper.

Mr. NAUGHTON. I suspect you are using the same computers in Baltimore that are handling some of my charge accounts.

Mr. TIERNEY. I don't think we have farmed out anything to the department stores, but I have had the same problems. I once got a $75 sweater free because they said they couldn't fool with me any more.

Mr. FOUNTAIN. Have there been occasions when the Blue Cross National Association has instructed local plans to disregard and not follow instructions issued by SSA?

Mr. TIERNEY. Yes, I think of two instances, and maybe Mr. Mayne can think of some more.

Mr. FOUNTAIN. Can you give us the details?

Mr. TIERNEY. Our professional relations people put out a bulletin one time asking that they be furnished copies of everything a plan put out in the way of professional relations information or bulletins or directives or anything else. And the BCA balked; they said that under the contract, we didn't have any right to demand any such wholesale sending of things. They had sent things they thought were pertinent and affected medicare, but they weren't going to send everything else.

Well, we worked that out, I think, to our mutual satisfaction. Perhaps we had asked too much.

On another occasion, a request for information related to the problem of determining—and I think we touched on this the other day—the appropriate amount of owner's compensation, where the owner of a proprietary institution is the administrator and where he determines his own salary. It became obvious early in the game that we had to get some kind of a fix on what comparable administrators were being paid in comparable institutions, on an arms length basis, where they were not the owners.

So we asked all intermediaries to compile, together with our regional officers, information to this effect. BCA people at that time took the position that they would go out and compile all the information for

our regional office, but not compile it together with the commercials. That would be up to the regional office.

Well, again that seemed a little bit overzealous guarding of prerogatives.

As far as I am aware, sir, these are the only two times they refused to follow our directives.

Mr. FOUNTAIN. You worked that out satisfactorily?

Mr. TIERNEY. We got the information. We could have gotten it more reasonably.

Mr. NAUGHTON. That creates problems for you, doesn't it, if your prime contractor is telling your subcontractors not to follow your instructions and cooperate with you?

Mr. TIERNEY. I think in 4 years, if I can only think of two instances, it hasn't been a major problem.

Mr. MAYNE. I can think of one other that we resolved, and resolved pretty firmly.

It's a requirement that the plans as subcontractors submit audit subcontracts to us for approval. And in several instances, the Blue Cross Association told the plans to go ahead and approve the audits before receiving on approval.

So we had a session on this with Blue Cross Association, and they said, well really they didn't mean what they said; it was all worked out.

Those were I think only about three, weren't they, Bob?

Mr. OULOOSIAN. Yes.

Mr. NAUGHTON. You are not sure those are the only instances that occurred?

Mr. MAYNE. I would say in that area, yes.

Mr. NAUGHTON. I am speaking of instances where Blue Cross-Chicago has told local plans to disregard instructions. Are you saying that three is all there are, or three is all you can think of at the moment?

Mr. MAYNE. What we are saying is these three are the ones that come to mind.

Mr. FOUNTAIN. What was the explanation?

Mr. TIERNEY. The explanation I think, Mr. Chairman, was their legal interpretation of the specific provisions of the agreement, what they had a right to do under the agreement—and I am sure Mr. Naughton has a copy of it—it sets forth the functions of the intermediary. And their basic position is that you have contracted with us to carry out these functions, now it is up to you to make an appraisal of our overall performance and see how we are doing it. It is not up to you to tell us how to do it.

Our position from the beginning was that maybe that was the way the contractor read it, but it is quite clear in the law, quite clear in our concept of the contract, that it is up to us to tell you how to do it in some instances, and that has been the basic conflict.

And I don't want to leave the impression with you that this is totally tied up with BCA. On the part B side, we have this with carriers all the time. It is spelled out specifically in the contract that they are to make determinations of what a reasonable charge is. We are constantly sending out directives telling them how to do that, and many of them

say, you go fly a kite, you contracted with us to make those determinations.

So we have had this kind of abrasive operation which I think you would expect between a Federal agency which has contracted out these services, and yet continues to feel a responsibility to see that they are done effectively.

Mr. FOUNTAIN. I didn't mean to single out the BCA.

Mr. TIERNEY. I was just afraid we were leaving that impression.

Mr. FOUNTAIN. We did have individual instances brought to our attention, but we are interested in others too.

Mr. NAUGHTON. Of course, BCA's situation is the only one where you have a third party between you and the intermediary that has the direct contact with the provider.

Mr. TIERNEY. Yes, you are right.

Mr. NAUGHTON. May I ask—you mentioned one of the situations with Blue Cross-Chicago, where it instructed the local plans to disregard requests for information. It involved a request on the part of social security for copies of all the promotional material, instructional material being sent out by Blue Cross, local plans or national distribution, to the providers with which they were dealing. Did any of that promotional material—I guess you may not know, since you evidently didn't get it——

Mr. TIERNEY. We got everything involving medicare.

Mr. NAUGHTON. Are you sure you got it all?

Mr. TIERNEY. I am not sure.

Mr. NAUGHTON. Were any of those perhaps suggestions to the providers to use the combination method and get part of the cost of delivery rooms paid by medicare?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. You really don't know whether it was or wasn't done, do you?

Mr. TIERNEY. I am not aware—maybe you are—of any Blue Cross plan ever sending out a directive to providers saying use the combination method. If you are, I would be glad to know of it.

Mr. NAUGHTON. Mr. Mayne, are you aware?

Mr. MAYNE. No.

Mr. NAUGHTON. Are you sure, where an intermediary suggested to a provider——

Mr. FOUNTAIN. He said he wasn't aware.

Mr. MAYNE. I couldn't answer that.

Mr. TIERNEY. We are talking about written material, Mr. Naughton. I think it is quite likely that an intermediary, in dealing with a provider, would point out the alternative methods and suggest that it use whichever one it had an option to use. I am simply not aware of any written directive to that effect, and if you are, I would be glad to know about it.

Mr. NAUGHTON. At the moment, Mr. Chairman, I am not aware of any actual written communication between the intermediary and the provider, suggesting that some course of action might get them more medicare reimbursement. There is evidence of oral communication of this type.

Mr. FOUNTAIN. Have you been seriously dissatisfied with the performance of any of the Blue Cross local plans?

Mr. TIERNEY. Well, Mr. Chairman, any time you have this kind of a range of plans there emerges a pattern of very good ones, middle-of-the-road ones, and obviously some have to fall at the bottom end.

These may arise out of a number of things, such as lack of capacity to process bills efficiently and effectively, and keep the thing moving.

There may be an inordinately high cost per bill in one plan as compared to the national average. We are constantly looking at the plans. We have information on their average processing time, their bills pending over 30 days, their cost per claim processed, all of the different criteria we have developed in order to evaluate plans.

And there are frankly plans which have not done as effective a job as we think they should, and we will be taking a look at those plans as I told you in the renewal of the contracts in July.

There is always the question, Mr. Fountain, and I don't mean to beg the question, but on both the carrier and intermediary side, you have organizations in which you have now invested 4 years of time and money and personnel, and they have developed to a level. You are therefore faced with, will we junk all that and throw it aside and start all over with a new guy who has to do the same thing all over again, has to develop the capacity and personnel and computer and what not.

It's a difficult judgment to make, and our basic philosophy has been to—on both the carriers and intermediaries—try to bolster the performance, improve what we have.

In two or three instances, we decided it was no use making further effort and we made changes, and we may do that again in the future.

Mr. FOUNTAIN. As a practical matter, do you feel you are in a position to terminate the use of individual Blue Cross plans whose performance may not be adequate?

Mr. TIERNEY. I think that is probably a legal matter, Mr. Chairman. The contract says that the Blue Cross Association can terminate a subcontract. I personally think that there is no question but that for cause the Secretary, after hearing and all the rest of this involvement, could terminate a contract.

Mr. FOUNTAIN. I guess for reasons you have already explained, unless it were essential, you wouldn't want to terminate a contract, but it seems to me that that is a question that ought to be answered as to whether or not you have that right.

Mr. TIERNEY. It certainly would seem there should be no question about the authority to do so.

Mr. Mayne is pointing out what I though I said—we have nothing in the subcontract with regard to nonrenewal. We do have provision for termination for cause.

Mr. FOUNTAIN. Does it list the causes or is that within the discretion?

Mr. TIERNEY. That is a matter of discretion, but it requires a hearing.

Mr. NAUGHTON. Have there been any involuntary terminations of intermediaries contracts?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Either Blue Cross or commercial?

Mr. TIERNEY. There have been four terminates of part A intermediaries or part B carriers, Mr. Naughton.

Mr. NAUGHTON. What were the reasons for those?

Mr. TIERNEY. Well, largely in two of them it was simply lack of capacity. They were just out of the picture and there wasn't any question we had to put somebody else in.

Mr. NAUGHTON. Unsatisfactory performance?

Mr. TIERNEY. Yes, sir. The other two were more or less mutual agreement, that it was perhaps impossible for them to be totally effective. I should correct myself. In one, it was more of a voluntary termination. The company simply said, we have given this 3 years of good try, and we think we have done our share, and we would just as soon get out.

In the fourth one which is just underway, there was a mutual agreement that although this is a very excellent company, it was operating in only one State, quite far away from its home office operation, and in the best interests of the program, we should terminate.

This was, in effect, a mutual agreement, rather than a unilateral termination.

Mr. NAUGHTON. Would that be two by mutual agreement and two more or less involuntary, where you said "You are not performing and we have to call it quits"?

Were any of those Blue Cross or were they all commercial?

Mr. TIERNEY. They were all commercial.

Mr. NAUGHTON. So that out of less than a dozen commercials that you started with as intermediaries, by mutual agreement on two and more or less involuntary on the other two, you have dispensed with their further participation?

You have what is it—74 Blue Cross plans? And there have been none of these terminated?

Mr. TIERNEY. No.

Mr. NAUGHTON. Of course, there is some question as to your legal authority under the contract to terminate.

Mr. TIERNEY. There is no question about our being able to terminate them for cause, Mr. Naughton, by showing they are ineffective and inefficient. As you pointed out, the law says the providers of services will have the right to nominate an intermediary and unless the Secretary finds that they are ineffective or inefficient, he will accept that nomination.

Now if he is going to make a finding of ineffectiveness and inefficiency, he is going to have a hearing and prove that allegation. That hasn't been done in any Blue Cross instances.

Mr. NAUGHTON. Are all of the 74 local Blue Cross plans in your judgment doing a more effective and efficient job than either of the two that were terminated? I mean, was their performance substantially worse than that of any Blue Cross plan?

Mr. TIERNEY. Yes; I think they were.

Mr. NAUGHTON. All 74 Blue Cross plans are doing substantially better?

Mr. TIERNEY. Than the four that were terminated; yes.

Mr. NAUGHTON. What is the basis for your conclusion to that effect? Is it based on statistics?

Mr. TIERNEY. It is based on the criteria that I am sure you are familiar with, Mr. Naughton. Their processing times, their costs, and so forth. Mr. Mayne can go through the whole list of things on how we evaluate the performance of intermediaries and carriers.

Certainly in answer to Mr. Fountain's question, there are some Blue Cross plans that are on the low end of the scale, have high costs for doing an ineffective job, and I don't mean for a minute to say they are doing on the whole a better job than commercial intermediaries.

But they represent 93 percent of the hospitals. The commercials have the balance—and our own direct reimbursement branch has a portion of the balance. As Mr. Mayne pointed out, the ECF portion splits roughly 50–50. Blue Cross has a little more than the commercials. The ECF operation as you know requires a much more intricate and difficult type of intermediary role than the hospital portion.

Blue Cross didn't have any greater experience with ECF's or nursing homes than the commercials, and I think it is even steven.

Some commercials do an excellent job, some less excellent than Blue Cross.

Mr. NAUGHTON. Could you provide the subcommittee with a comparison showing the statistical factors that led social security to conclude that the four who are no longer with the program—or the two, whichever was the case—should be terminated, and comparing that with those Blue Cross plans which are on the low end of the performance scale.

Mr. TIERNEY. I am sure we can give you that.

(The information referred to appears on p. 134.)

Mr. NAUGHTON. Have you ever expressed to Blue Cross in Chicago serious dissatisfaction with the performance of one or more of the local Blue Cross plans, Mr. Mayne?

Mr. MAYNE. Yes, indeed. And of course through our contract performance review we, identify deficiencies in performance. The Blue Cross Association receives a copy of the report. We expect comments from them. Then the implementation of our recommendations is checked on through our own regional offices.

Mr. NAUGHTON. What were the more serious complaints that you made to Blue Cross-Chicago about performance locals?

Mr. MAYNE. They would pretty well run the gamut in some cases, we had concerns about their claims-processing operation, the time they were taking.

Mr. NAUGHTON. To pay out?

Mr. MAYNE. That is right. In other cases we had concerns that they had not proceeded with the effective development of utilization safeguards in line with general instructions.

We had concern, as I am sure you know only too well, about the handling of the provider audit in a number of situations.

There would be situations where we had questions about their query process, the degree of error in it. With a high degree of error, this of course falls back on the provider, on the hospital, causes delay, causes additional work.

So there are a great range of things. These would be brought to the prime contractor's attention as well as the subcontractor.

Mr. NAUGHTON. What kind of action did you get from the prime

contractor? Do they have an obligation under the contract to clean up deficiencies?

Mr. MAYNE. They do, and where we have had several serious situations, they have, without waiting for one of our contract performance reviews, sent in teams of their own. They have spent as much as a week or 2 weeks in a plan; some of these have resulted in a complete reorganization of the plan's work in the medicare area.

Mr. BROWN. Assuming they didn't take that action, would you have cause to terminate the contract under the terms of the contract?

Mr. TIERNEY. Yes, I think, Mr. Brown, that if we directed them to take action, and they refused to take action—this would be cause to terminate a contract.

Mr. BROWN. I think it would be cause, but does the contract specifically indicate it would be?

Mr. TIERNEY. Well, the contract is drawn in broad terms. For cause, the Secretary may terminate the account.

Mr. BROWN. Who drew that contract up?

Mr. TIERNEY. The Department's General Counsel.

Mr. BROWN. When was it drawn? Do you know the individual and/or the time that the contract was drawn, and the responsible party for drawing it?

I listen to this contract discussed, and it sounds to me like I could have drawn that contract and I am a newspaperman, not a lawyer.

Mr. TIERNEY. The original contracts were drawn in the spring of 1966.

Mr. BROWN. Who was the General Counsel of the Department in the spring of 1966?

Mr. TIERNEY. Alanson Wilcox. His Assistant General Counsel assigned to the Social Security Administration, Bureau of Health Insurance, was Melvin Blumenthal.

Mr. BROWN. Were they the parties that drew the contracts, or was it drawn in the Secretary's office?

Mr. TIERNEY. I wasn't here at that time, but I assume they as counsel for the Department approved the contract. The contract went through a long series of negotiations between the parties, and ultimately emerged a contract which had the approval of Counsel's office.

Mr. BROWN. Are these people still in the Department?

Mr. TIERNEY. Mr. Wilcox isn't. Mr. Blumenthal is.

Mr. FOUNTAIN. Do you know enough about the background of the preparation of the contract to express an opinion as to whether or not the question of putting the specific for cause items in the contract was a matter of serious negotiations?

Mr. TIERNEY. I would have to have Mr. Mayne reply to that. I wasn't around at that time.

Mr. FOUNTAIN. The contract just says for cause, does it not?

Mr. MAYNE. Yes, it says if the Secretary finds that there is not effective and efficient administration.

Mr. FOUNTAIN. That language is in the contract?

Mr. MAYNE. That language is in the contract. The language is very similar to the language in the statute itself. I did not participate in the negotiations of the contract, but it is my understanding that the whole pattern was formed along the lines as identified in the statute,

and with the concepts that were brought out in the committee reports as to the role of the intermediary.

Mr. FOUNTAIN. When does the prime contract with the Blue Cross national association expire?

Mr. TIERNEY. June 30 of this year.

Mr. FOUNTAIN. Does SSA expect to renew the contract on the same terms?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. What major changes do you intend to insist upon? You mentioned some, but perhaps you could summarize them for us.

Mr. TIERNEY. I think clarifying the situation we have discussed, Mr. Naughton, making it clear that the Secretary has direct access to the plans, making it clear that the Secretary has an unqualified right to not renew or to terminate a contract with a subcontracting plan.

We had as a matter of fact plans to start negotiations this morning on a new contract, until the committee session was held. We have compiled a list of items we intend to negotiate.

I am not trying to be defensive with Blue Cross Association, Mr. Fountain, but I would hate to have left on this record an impression that this was a total unilateral and arbitrary contract that has not resulted in effective and efficient administration of the program.

I think it can be improved, but I don't think it has been a major problem in the administration of the medicare program. I think most of the plans have done a very effective job of it.

You see, sir, these are absolutely autonomous local organizations. Five or six good and true men. Some place back in the early 1940's they got together and formed a Blue Cross plan.

And the Blue Cross Association as such had no being at that time. So you aren't dealing with a homogeneous thing like the Traveler's Insurance Co. You are dealing with 74 totally different, totally autonomous organizations. And you just couldn't expect them all to be of the same caliber and the same performance.

I think in that respect, BCA has had a good effect. It tries to bring them all up to a level.

Mr. BROWN. It seems to me there are a number of questions that hover around this point.

One is whether or not Blue Cross and the other contracting intermediaries perform the services that were called for by the contract.

In other words, have they lived up to the contract? And I gather that what you are saying is that you feel they have lived up generally to the contract. Is that correct?

Mr. TIERNEY. Yes, sir.

Mr. BROWN. Then the next question is whether or not the contract worked up by the Secretary when this program started is an appropriate contract, and does all the things that a contract should do, and I am inclined to think that a very poor case for a positive answer to that question has been made.

As a matter of fact, I must conclude that the contract, apparently as you have concluded, does not do or does not provide the Social Security Administration the kind of control and information, ready access to that information, that you would like to have, is that correct?

Mr. TIERNEY. I am sure any contract can be improved, Mr. Brown.

I don't think that our lack of information, or our inability to have totally up-to-date data arises out of the contract.

It arises out of the capacities of the entities involved. The contract—and I don't know whether you have seen it—spells out distinctly what the functions of the Secretary will be, what the functions of the intermediaries will be and the subcontracting intermediaries, and with experience, we think there ought to be some changes in those functional descriptions, but I don't know if the committee's counsel has determined any specfic area where there is really a weakness in the contract.

I think this whole concept of whether or not there should be any interference with the Social Security Administration's direct contact with the local plan, that is a weakness, and ought to be climinated, but I don't think that lack of information has arisen out of any weakness in the contractual relationship. Where we haven't gotten information, it is normally because they don't have it.

Mr. BROWN. You did indicate, however, that you were going to renegotiate the contracts and improve those contracts so this would lead me to the conclusion that there is some feeling on your part at least that the contract under which you are currently operating with the intermediaries is not adequate or totally satisfactory.

Mr. TIERNEY. It is not totally satisfactory, sir, and that is true not only of the contract with BCA and commercials but on the part B side with the carriers.

Mr. BROWN. It seems to me the other point involved here is whether or not you all have acted aggressively to get the information and give the guidance that you had a right to give under the contract, and in turn, whether or not, regardless of the nature of the contract, the various intermediaries did an adequate job with the responsibility to which they have been assigned under the contract, and I would like to have your comment on that latter point.

I suppose the judgment on whether or not you all pursued your responsibility under the contract is a judgment we would have to make or could more directly make than you could. But what about whether or not the intermediaries, regardless of the contract, have exercised their full responsibility in the program? Is that what your comment alluded to a moment ago?

Mr. TIERNEY. Well, Mr. Brown, I don't want to beg your question. I said before some of them have certainly done a better job than others. I am not aware of any intermediary that has failed to perform its functions under the contract. That doesn't mean it has performed them 100 percent or always on time or carried out every facet we would like to see done, but there has not been a case, other than those I alluded to in replying to Mr. Naughton, where we felt that the performance of the intermediary was so bad that it warranted termination of the agreement.

This has been a massive program. It's something brand new. They didn't have experience with this type of thing, and it's been a painful process.

I am sure you must recall the time when the great problems of medicare were the vast pipeline full of bills and nobody could get a bill paid timely. Those are the problems we attacked first.

Then we attacked the problems of perfecting mechanisms to make it possible for them to fully perform on a totally acceptable basis. We

think we made a lot of progress and they have made a lot of progress, but there is still somebody who is doing a better job than the other guy.

But in direct answer to your question, I don't think any of them have, either through default or through refusal, failed to carry out the functions that were given to them under the contract, or to make an honest effort to do so.

Mr. BROWN. My question, however, was, do you feel that regardless of the requirements of the contract, they have fully exercised what you would consider to be good public responsibility with regard to the functions that has now developed for intermediaries in connection with the program?

I'll put it another way—are there aspects of their performance which you now feel should be required under the contract, which are not currently required under the contract?

Mr. TIERNEY. I don't think that there are aspects of the performance that aren't required under the contract. For example, Mr. Brown, we talked the other day about this whole effort to make this fine judgment of whether or not a case in an extended care facility is a covered benefit or not.

Some of them have done a very good job of this. Some of them frankly have done a very bad job of it, and our effort has been to see to it that they increased their abilities.

The same is true of home health agencies. Again we have a very limited, defined benefit. In the early days of the program, I think there is no gainsaying the fact that many intermediaries did not try to make that fine decision. They paid the bills. We have tried to perfect that.

Now, that didn't arise out of anything that is in or out of the contract. It arose out of an inability and lack of experience in the administration of that kind of a benefit.

Mr. BROWN. What occurs to me in this is that if you are going to require additional performance under a new contract, you may very well find yourself in the position where you either do not have the intermediaries eager to perform this function, or you will have to make a judgment as to whether or not the intermediaries are to perform this function at a certain fee, which adds to the cost of the program. Hopefully a fee which would by the process of its being earned, might reduce some other aspects of the program to the taxpayer at least. Or whether that function which the intermediaries now perform is to be performed by some other agency, possibly your own organization, or some other aspect of private or public enterprise, private industry or Federal Government.

Have you moved toward any thinking in that area?

Mr. TIERNEY. No, sir, we certainly haven't moved toward any thinking that the Federal Government would take over any of the present major functions.

I don't think we have in any agency certainly not in our agency—the capacity, sir, to go out into the country and start doing the job that the intermediaries are doing. This would take a great deal of tooling up.

On your other question of whether or not there should be an incentive built in, as I said, the Senate Finance Committee staff report urges that consideration be given to that.

I think you put your finger on the point. If you are going to start paying something in addition to what is now being paid, which is pure cost, it has got to be with some assurance that out of that payment is going to come a more effective administration of the program, that is going to result in a gross savings.

We have given some thought to that. The companies for the most part were pushing for that. On the other hand, I think they find it difficult to know just exactly how to structure this sort of a thing. It is not unlike I suppose some of the problems the Defense Department faced. They did have to some extent instead of a pure cost contract, the carrot out here where if you do better, you make something out of it. Just how much that carrot should be. I don't know.

Mr. BROWN. Wait a minute, I want to check you on that point.

If you do better you make something out of it. You are talking about the guy that is receiving the money in the long run anyway.

Mr. TIERNEY. I am talking about the intermediary, not the provider. We have also talked about providing incentives to the provider.

Mr. BROWN. But who are you talking about in the Defense contracts?

Mr. TIERNEY. I am not totally familiar with the Defense contracting situation, but as I understand it, there was an effort to depart from pure cost contracting in the Defense Department on an incentive to a more effective doing the job, and allowing something over and above if they did prove more effective.

This is what I think you are talking about, if you are going to pay these people something over their cost. It sounds good and makes some sense, but I don't frankly know, and I am not sure they know how we would go about that.

Mr. BROWN. If I might make an observation. I sit on another committee in the Congress, the Joint Economic Committee, which has gotten into a discussion of this whole area of defense contracting. And in this area, the job of checking the contracts and the performance of the ultimate contractor is a Federal function. And we have had, as the headlines have shown, a considerable problem in this area when the work has been done by Federal employees checking the Defense contractors.

Because it boils down to whether or not you are going to buy the system at the price the ultimate producer sets on it, and negotiating between those two. It seems to me we have a different kind of situation with the intermediaries, who really are private industry that have taken on this responsibility, for whatever reason, and hopefully they should have some incentive to see that the system operates as efficiently as possible.

But it occurs to me that unless there is an incentive built in for them, that there is no reason to expect that they would do a better job than the Government has done in some other areas of private contracting.

Short of a restriction in the contract which would provide the stick—in other words, that you beat them if they don't do a better job—and that is going to keep a lot of people from wanting to do the job at all.

Where are we headed then in this middleman position? The intermediary's responsibility for exercising this judgmental, discretionary, but highly important and in many ways rather expensive responsibil-

ity of approving and disapproving payments—is there some thought of getting into this? The incentive system of making money out of saving the taxpayer money?

Mr. TIERNEY. Yes, there is some thought, but as I say, our thoughts certainly haven't crystallized in this area, because it is a much different thing, as you well pointed out, from the typical Government contract operation.

I do think there is this incentive, sir; every one of these organizations is involved in its own private operation in the health care system of this Nation, and it has just as much a stake in seeing that services are delivered as economically and as efficiently as possible in its own operation as it has in ours.

Mr. BROWN. But there is one rather distinctive difference, that if they have high costs to the producers, the services which their insureds use, then those costs have to go back to the insured in terms of higher premiums and their system becomes less competitive with the system of some other private competitor in this same field.

And so you have really got the pressure on them as business operation to keep those costs low, to see that nobody is unduly profiting on them.

I don't see that they have the same pressure with reference to the federal system to which the taxpayers generally contribute in terms of the medicare contribution.

Mr. TIERNEY. I think they have.

Mr. BROWN. It isn't the whole body politic that contributes of course, but it is the people who participate in medicare, and I don't see what the incentive is, what the loss is for the intermediaries in this connection.

If they don't do a good job, Social Security raises medicare premiums. If they do do a good job Social Security doesn't have to raise them quite so fast, but it is no skin off their nose one way or the other, is it?

Mr. TIERNEY. There is no direct financial involvement. You are right, sir. Other programs have been developed in different ways.

As you know, the Federal employee health programs are underwritten programs. The premiums of course have increased in those programs. I think I testified to it the last time I was before the committee. I don't have the figures with me now, but I stand ready to be corrected, and I would like to reserve the right to correct the record if I am wrong.

I think I testified they have gone up in the last 3 years, 61 percent in the service plan, and 73 percent in the indemnity plan.

So I don't know that that is the answer. Just putting the monkey on their back. The costs of health care in this Nation are going up in the private sector and in the public sector. I think all we can hope to do, Mr. Brown, is to develop a surveillance organization in every region and in our own central office to make sure that every intermediary is operating as efficiently and effectively as we can prod them to do, and where we find that they are incapable of doing that, eliminate them.

Mr. BROWN. If they get tired of being prodded, let them eliminate themselves.

Mr. TIERNEY. That is our only ultimate weapon now, and perhaps it is too much of an overkill. If that went on forever, you would wind up with just whoever was willing to continue the operation.

I am not arguing against giving them an incentive, but you can't tie it to benefit payments. It is awfully hard to tie it to a tangible operation. You could say, for example, well, if you cut back the claims we will pay you a premium. This may result in simply passing on more of the load to the beneficiary and saving the program money, but nevertheless, the aged person is then paying more of it.

So that doesn't seem to be a viable approach. The Congress was quite clear that these people would operate on a nonprofit, no-loss basis; that their actual costs of administration would be covered, and that's it. That is the way we are still operating.

Mr. BROWN. If I may conclude with the observation that it seems to me when we get into these Federal programs, we run into the problem of who has the incentive of competition, of profit, to make the system operate efficiently.

And I am not sure that with an intermediary that makes nothing or doesn't benefit in the profit sense or the competitive sense—if that is a fair assumption; I am not sure it is—out of the service it provides as an intermediary, that you have a system that is very different from letting the Government take it over, and there is no incentive apparently other than public service on the part of those people who operate the Government system, to see that it operates as efficiently as possible.

Maybe we have dug ourselves into another one of these traps out of which there is no real sound route. It's one of the problems, incidentally, which some people pointed out when we got into the consideration of medicare initially, but I wish we could find some resolution of this problem; some recommendation from the Social Security Administration or elsewhere as to how we can avoid that trap of cost overrun type of negotiation that we have in the defense aspect of Federal-private industry relationships, that would see us in this Federal-private relationship avoid what is the usual result, the taxpayer pays, and pays, and pays.

Mr. TIERNEY. Well, I share that concern, and that desire with you, sir. I think, to put this thing in perspective, the total administrative costs of the portion which this committee has been concerning itself with is a very small portion of the total costs of the medicare program.

The cost not only of all of the intermediaries but of the Social Security Administration and the district offices runs for 1969 in the neighborhood of 1.15%. This is the ratio of administrative expense to benefit expense excluding the cost of provider auditing.

Now, that is an awful lot cheaper than most commercial companies or Blue Cross plans run their own business. And for understandable reasons, they don't have enrollment or sales or billing problems.

But 1.15 percent I think gives you some assurance that the administrative aspect of this thing isn't running out of control.

Mr. BROWN. Well, really that 1.15 is the cost of the insurance adjuster—what would be the insurance adjuster in an automobile claim, in effect, isn't it?

Mr. TIERNEY. Not only the adjuster, but the payment.

Mr. BROWN. Obviously no sales and some of the other things you mentioned——

Mr. TIERNEY. The recordkeeping and payment process and that type of administrative operation, carrying out their functions. We don't of course cover any of their sales costs or advertising costs or any other portion of those costs.

Mr. BROWN. If we eliminated all those other costs and got down to what an intermediary is spending on the medicare program as opposed to what it is spending on its own program, whether those two figures would relate and if they did not relate, I would suspect that perhaps they would be more concerned about their own program with reference to whether or not they were paying unworthy claims and so forth, than they would to the cost of administering the program to determine whether medicare is paying unworthy claims.

Mr. TIERNEY. I think you would find them quite comparable, sir, and I would attempt to get them for you if you are interested.

Off the top of my head, and you can ask the Blue Cross people if you choose to have them in here, I think the average administrative expense ratio of the Blue Cross plans of the country is around 5 percent. That covers their other activities.

But on the pure claims processing, recordkeeping, query, the functions they perform for us, I think you would find that 1.15 percent is below what it costs them in their own business.

Mr. BROWN. I think this is a matter we could only determine from Blue Cross and it might be worthwhile to have someone from Blue Cross and other private companies that are intermediaries appear before us and discuss this whole issue. I think it has some interesting aspects to it from which we can only presume their viewpoints, and we might be better advised to get them directly from the people involved.

There are other statistics that I would much prefer to see us spend our time trying to obtain, than that one in particular. Thank you.

Mr. FOUNTAIN. I assume you envision that the intermediaries will likewise have some questions they would like to raise about some provisions they would like to have in the contract?

Mr. TIERNEY. Yes, I think they will, Mr. Fountain. As I said before, this is an abrasive relationship in the final analysis, because they are doing a job, and we are looking over their shoulder. They think we overdirect. I am sure they would like to see a little more freedom of operation. I am not aware of what they will be asking about.

Mr. FOUNTAIN. Mr. Naughton has a question.

Mr. NAUGHTON. Mr. Tierney, some of the people who work under you have a little more unhappy attitude about the effects of trying to work through Blue Cross-Chicago in dealing with local plans, do they not, than you have expressed here?

Mr. TIERNEY. I don't know about the degree of unhappiness. Yes, some of the people find that we run into problems and they are quite dissatisfied with the way it operates.

Mr. NAUGHTON. Do you recall a September 23, 1969 memorandum from Fred B. Wolf who, I believe, is regional representative for the health insurance program in Chicago region?

I can read part of it to refresh your recollection.

Mr. Wolf, in his memo to you, indicated that:

We wrote each intermediary on August 1 requesting a list of providers who have rendered little or no service to medicare beneficaries for an extended period of time. I have since learned that George Hasapes of BCA—which is the Blue Cross Association—instructed all the plans in this region not to furnish the information I requested, and that he has again written to Bob Ouloosian concerning the matter.

It seems to me that a refusal of a contractor to supply basic, simple, uncomplicated information to be used for official purposes in administration of the medicare program is a breach of contract. I certainly agree with what Secretary Finch said on "Issues and Answers" on Sunday, September 21, when he said "We don't have rational control of the medicare program."

While this particular issue is relatively a minor one, the principle is important. We must insist on the prompt receipt of available information when requested for official program purposes.

So long as BCA exercises a veto over SSA requests, we will never be able to have rational control over this program. Since BHICO—

What is that?

Mr. TIERNEY. Bureau of Health Insurance, Central Office.

Mr. NAUGHTON (continuing).

* * * has responsibility for administrative, legal and contractual negotiations. with BCA, I am requesting your assistance. Please contact BCA and instruct them to furnish the information I have requested in my letter of August 1.

Thank you for your assistance and let me know the action you have taken.

This was September 3, 1969. Has the information been furnished?

Mr. TIERNEY. I don't know.

Mr. MAYNE. I really don't know. The issue now is the one we were discussing earlier, that BCA's position was not that they didn't want to give the information, but that having the responsibility for supervision of the plans, the request should have come through them for their coordination.

This was their problem.

Mr. NAUGHTON. Well, of course, Mr. Wolf's views are on the record.

Mr. TIERNEY. As I think Mr. Mayne pointed out, Mr. Wolf had written to each plan. This has been the problem. BCA says don't go to each plan, come to our regional office, and we will get the information.

Now, we will find out for you whether or not the information was secured, but I totally agree with Mr. Wolf that that to me seems something that we have to totally clarify.

Now their position is, we are the prime contractor, we are responsible for this operation. If you want the information from the plans in Mr. Wolf's region, ask us for it and we will get it.

Mr. Wolf is saying that's crazy, I will get it myself directly. And that is something we have to clarify.

(The following chronology of significant events related to the September 23, 1969 memorandum from Mr. Wolfe was subsequently supplied:)

On August 1, 1969, Chicago RO requested information by letter from all Blue Cross plans and commercial intermediaries regarding providers with little or no medicare business. Unfortunately, in the letter the RO indicated that, where there has been no medicare business, the provider need not file a cost report.

On August 11, 1969, BCA sent a telegram to all plans advising them not to comply with the RO request. On the same day, BCA wrote BHI, Baltimore, questioning the position reflected in the regional letter that a provider with no medicare business need not file a cost report. BCA questioned this and stated that it conflicted with its previously issued instruction to all the plans that in such cases the provider must file page 1 of the report.

In the first week of October 1969. BCA, after an exchange of correspondence with us which resulted in our agreeing with BCA that page 1 of the cost report should be filed where there was no medicare business, instructed the plans to provide the Chicago RO with the information requested.

To date, information has been received from all plans.

Mr. NAUGHTON. I think you indicated you were somewhat unhappy with some provisions of the contract with the commercial insurers which do not involve BCA.

What significant provisions, if any, of those contracts are you unhappy with? Or what did you feel should be changed?

Mr. TIERNEY. I don't think on the part A side there are any significant changes in the contracts. On the part B side I think there was more concern.

Mr. NAUGHTON. You indicated that the use of wire services maintained by BCA with its local plans was very beneficial in the operation of the program, and I am sure it is. What arrangements do the commercial firms who are acting as intermediaries make? They don't have the BCA network available to them?

Mr. TIERNEY. No; and they contact us on another kind of network.

Mr. NAUGHTON. Do you find the cost of whatever arrangements the commercial insurers have substantially greater than the BCA cost?

Mr. TIERNEY. The query operation?

Mr. NAUGHTON. Yes.

Mr. TIERNEY. I don't have those figures on the top of my head. We can try to get them.

(The following information was subsequently supplied:)

A meaningful comparison cannot be made of the costs of transmitting medicare queries by commercial insurers as opposed to the query operation of the Blue Cross plans. This comes about from the variety of transmission media used by the commercial firms, which Mr. Mayne mentioned in his testimony to the subcommittee on March 3, 1970. For example, some insurers incur no direct communications cost except for the cost of transporting the data to a local social security office or payment center, where it is transmitted to Baltimore. On the other hand, some commercial firms use a device installed at their location for transmission to Baltimore via the GSA advanced record system. This mix of transmission modes does not provide for a comparative measurement of medicare transmission costs between the plans and the commercial firms.

The advantage of the Blue Cross wire system, as compared with the methods used by the commercial insurers, would lie in its sustained efficiency and reliability of performance. The use of a network system to gather and transmit queries makes for a high degree of control and uniformity not always possible with the use of assorted systems. In terms of economy, however, we are trying to determine if there might be a better alternative to any of the curent systems used for transmitting medicare data. While basic policy considerations must still be faced, a preliminary study on alternatives to the BCA system has been completed.

Based on summary-type data available on BCA wire costs, three systems alternatives were considered; i.e., (1) use of the GSA advanced record systems (ARS); (2) combined use of the ARS and new dedicated SSA facilities; or (3) exclusive use of new dedicated SSA facilities. The study indicated that, if the plans were to communicate directly with SSA, Baltimore (alternative 3 above), queries would continue to be processed in a timely fashion at less cost than the present way of doing business. As the cost factors used in pricing out the alternative systems were derived from summary data, however, any conclusion to supplant the Blue Cross, in whole or in part, would be highly speculative. Since the preliminary study points to a substantial savings (possibly $100,000 a year), it is our intention to arrange for an in-depth study of these and other communications systems possibilities to validate any actual savings potential. Such a study would also consider the integration of medicare queries from the commercial insurers.

Mr. NAUGHTON. What advantage if any is there to the Blue Cross wire system as compared with the methods used by the commercial insurers, either in terms of efficiency or economy— and you can provide that for the record if you would.

Does SSA have a wire network that you can also use for this purpose?

Mr. MAYNE. Yes, and some of the intermediaries and carriers are on our network. We have a variety of transmissions, depending on the local situation, both for intermediaries and carriers. In some situations we have magnetic tape transmitted by bus. In others, they have used our wire system with the sending instrument right in their shop.

In one or two instances, they utilized the instrument that is in our social security district office.

Mr. NAUGHTON. About how large a staff does BCA have?

Mr. MAYNE. I can probably give you an exact figure.

Mr. NAUGHTON. An estimate is all right. You can correct it for the record.

Mr. JONES. The average manpower for the last fiscal year in BCA was 126.6 man-years.

Mr. NAUGHTON. About how large was the manpower prior to the medicare program or their participation in it?

Mr. JONES. BCA employed 169 people before medicare came on the scene.

Mr. NAUGHTON. Is this 126 people simply the staff working on medicare?

Mr. JONES. That is the staff working on medicare.

Mr. NAUGHTON. How large is the staff that does not work on medicare?

Mr. JONES. The current staff is 274.

Mr. NAUGHTON. How does the size of the Chicago operation of Blue Cross compare with its size prior to the medicare program?

Mr. JONES. For the fiscal year 1969, we have added the administrative cost of the Blue Cross plans to that of medicare, and medicare as a percentage of the total is 21 percent.

Mr. NAUGHTON. I am trying to establish whether the Blue Cross Chicago office has grown substantially since the medicare program started? What was its manpower prior to the time they got involved with you on the medicare program?

Mr. JONES. From 200 to 300 employees, and these 125 people working on medicare would be by and large additions they have made.

Mr. NAUGHTON. The 125 working on medicare presumably are additions? But did they have 200 working on Blue Cross back in 1965, or did that end of the operation also grow?

Mr. TIERNEY. I think we would have to give you that figure. I don't know that we have it.

(The following data was subsequently supplied:)

Prior to medicare, BCA employed 169 people. The most recent figures show:

Employees involved in BCA work other than medicare	274
Employees directly involved in medicare	158
Total employees	432

Mr. NAUGHTON. Do you really need this wire system they have? Could you operate fairly well if you didn't have it?

Mr. TIERNEY. We would have to have a substitute wire system of some sort. You can't handle, as we handle, millions of claims and queries back and forth without a wire system. Now, we could substitute a wire system. I think the judgment made at the time of the contract was if I am not incorrect that there wasn't really then available a wire system. It would be a case of judgment.

Mr. NAUGHTON. Well, you do have a wire system now, Mr. Mayne?

Mr. MAYNE. No, I would like to clarify that. I was around at that time. There was serious consideration given to using the social security wire system which ties the Social Security district offices into the Baltimore computers. There were two problems.

One was that the capacity of our system was not equal to the load that was going to be taken on, nor could it be developed to accommodate that load in the few months that were available.

In the second issue, which was a policy issue and a significant one—with the role of the intermediaries in dealing directly with the provider, was it really appropriate to sandwich in the Social Security district offices between the provider and the intermediary for this important process of the receipt of admission notice, transmission, and receipt of responses as to eligibility, length of spell of illness, days left and so forth?

Mr. NAUGHTON. So you sandwiched in BCA instead, which may have been necessary at the time, because it was the only one available.

Mr. MAYNE. Well, the system we were looking at tied the social security offices to Baltimore. BCA ties the plans to Chicago to Baltimore.

Now we could not have devised a system that would have tied the plans to Baltimore, nor could we have expanded our district office system in time to have gone that route.

Mr. NAUGHTON. But between then and now, had you chosen that route, you could have expanded the physical arrangements and worked through the district offices, instead of Chicago?

Mr. MAYNE. We could do that. I think the basic policy issue still remains, and it is a serious issue.

Mr. NAUGHTON. You mentioned the cost of administration of the intermediary services. As I understand it, it is 1½ percent of the program payments on an average basis?

Mr. MAYNE. 1.15, exclusive of provider auditing.

Mr. TIERNEY. Fiscal year 1969 figures, total Blue Cross is 1.15. Total commercials, 1.16. Awfully close.

Mr. NAUGHTON. Now this is a percentage, of course. What does that represent in terms of dollars?

Mr. TIERNEY. Total Blue Cross administrative expenses, $47,263,-405 for fiscal year 1969. Total commercial, $5,965,537. Those figures are exclusive of provider auditing.

Mr. NAUGHTON. How much did provider auditing cost?

Mr. TIERNEY. Auditing cost for Blue Cross, $18,119,927. Total commercial, $4,453,303.

Mr. NAUGHTON. The Blue Cross figure is made up of 74 different plans, plus the Chicago operation.

If the average for Blue Cross is 1.15 percent of the payments made, you have 74 different figures going in to make that up. What is the high and low for Blue Cross operations in terms of the percentage?

Mr. TIERNEY. Let me take out the highest—the highest would appear to be 1.96, and the lowest would appear to be 0.56.

Mr. NAUGHTON. So there is almost 4 to 1 difference in the average administrative costs. Which is the highest and which is the lowest?

Mr. TIERNEY. The highest one is Wheeling, W. Va., 1.96. Of course, that is a relatively small plan with a relatively small claims volume, and you would expect a relatively higher cost.

The 0.56 is New Haven, Conn.

Mr. NAUGHTON. Which large plan has the highest percentage cost?

Mr. JONES. The larger plans, Boston has the highest, 1.46 Chapel Hill, N.C., would have the next highest, 1.42.

Mr. NAUGHTON. Does that cover most of the State?

Mr. JONES. That would cover the entire State of North Carolina.

Mr. TIERNEY. It's not a large plan as compared to New York or Massachusetts.

Mr. NAUGHTON. What is the figure for Washington, D.C.?

Mr. JONES. 1.37.

Mr. NAUGHTON. The Social Security Administration acts as direct intermediary through a unit of your own for those providers who do not choose to operate through either Blue Cross or one of the commercials. In your judgment, Mr. Mayne, how does the performance of your direct unit compare with that of the Blue Cross and the commercial firms in terms of economy and efficiency?

Mr. MAYNE. Well, the direct reimbursement operations is a quite different operation from anything that is present in the other intermediaries. The big difference is that it is nationwide, that it deals with a number of hospitals, particularly government, local government hospitals, that had no associations with other third parties in the past, whose choice was to come with the Federal Government.

There are certain other hospitals who, because of particular problems with other third parties, thought it would be to their interest not to have to deal with them again, so they elected to come with the Social Security Administration.

So that you do not have the situation of a concentration of providers, either hospitals or extended care facilities, as you do for most of the intermediaries.

You have a different type of provider. I think in some respects our direct reimbursement branch can serve as a laboratory for us, particularly in areas of utilizations control, in the refinements of the claims review process; and they have done just this. So that our evaluation of them as an intermediary would be quite different.

Mr. NAUGHTON. Recognizing they are not representative, how do they compare in terms of economy?

Mr. MAYNE. I will have to get the figure for the record. I have it on the charts.

Mr. TIERNEY. It is higher, Mr. Naughton. We deal for example, with California State hospitals, the mental hospitals. We deal with New York City hospitals. We deal with a lot of all-inclusive rate hospitals and it is a higher figure.

Mr. MAYNE. Sixty-seven of them in Puerto Rico.

Mr. NAUGHTON. In terms of the effectiveness of their performance, how do you think it compares? Do you have any trouble getting information from your direct branch?

Mr. MAYNE. Of course, they are not in my division, but I must say that when we want information on a particular problem, we have always been able to get it, certainly. Again, it's somewhat of a different relationship, being part of the family.

Mr. FOUNTAIN. May I ask a few questions now on the cost of intermediary services?

On what basis are intermediaries compensated for services?

Mr. TIERNEY. They are compensated on a no-profit, no-loss basis, Mr. Fountain. They submit budgets first of all to our contract financial branch—Mr. Jones' organization. Those budgets are reviewed and approved, and are then adjusted on the basis largely of workload during the year.

At the end of the period, they submit a final cost statement that is audited by the HEW audit agency, and final settlements are then made.

Mr. FOUNTAIN. How much have they been paid to date?

Mr. TIERNEY. Total payments to intermediaries to date?

Mr. FOUNTAIN. Approximately. I realize you can't be exact.

Mr. TIERNEY. For each of the 3 years, fiscal 1967, 1968, and 1969, the part A intermediaries, for administrative expenses, have been paid as follows: 1967—$30,589,166; 1968, $43,294,369; and 1969, $53,228,942.

Those are administrative expenses of their operations, Mr. Fountain. In addition to that, they have paid subcontracting auditing firms sums of $2 million in 1967, $12 million in 1968, and $22 million in 1969, in round figures.

Mr. FOUNTAIN. This is what they have paid out?

Mr. TIERNEY. For auditing. Auditing providers. You see, they subcontract with the major auditing firms of the country to do the auditing of the hospitals. This is a direct administrative expense of theirs. I think it is fair to segment that out.

Mr. FOUNTAIN. So to date you have had administrative costs to intermediaries of about $127 million total for 1967, 1968, and 1969?

Mr. TIERNEY. Approximately; yes, sir.

Mr. FOUNTAIN. They have had to pay out about $36 million for audits?

Mr. MAYNE. That is in addition.

Mr. FOUNTAIN. Is that pursuant to contract too?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. Do you feel that you have gotten your money's worth?

Mr. TIERNEY. Yes, sir; I think we have gotten our money's worth. I think you have to look at it this way, Mr. Fountain, without the intermediaries and the carrier system of the Nation, this program couldn't have gotten off the ground. I think in the overall, they have done an effective job of administering a very complex program.

In the beginning they did a quite ineffective job in many areas, and I think it's been a process of moving from one stage to another. At the moment, on the part A side, particularly, I think they are doing an effective job.

This is not to say that there are not problems. There are problems. With some plans still not having developed a sufficient computer capacity to carry the load. There are problems with some plans that have excessive personnel turnover and therefore develop high unit costs.

But I think they have done an effective job, and the Government has gotten its money's worth.

Mr. FOUNTAIN. Are there certain steps which you take to determine how well they are performing their responsibilities and if so, what are they?

Mr. TIERNEY. Well, very generally, sir, we have a number of surveillance activities. One is what we call our contract performance reviews through teams from the central office that go out at least on an 18-month cycle and make an indepth review of the operations of the program.

We have regional office people doing a monthly visitation of every operation, trying to pinpoint problem areas, and do something about them.

As I told Mr. Naughton earlier, we have, since late last fall, begun a program of putting an onsite representative in every one of the major carriers, and we hope in time—these are difficult people to recruit—we will have one in every carrier with some minor exceptions where there simply isn't a workload sufficient to warrant it.

In addition to that, we have a monthly reporting system whereby we gather data on the claims processed, the average processing time, the number pending over 30 days, the number of ECF bills denied, the number reduced, a whole list of criteria by which we try to evaluate their performance.

As a final step of course you have the HEW audit agency going in and reviewing their costs and wherever appropriate, the General Accounting Office going in and making its own independent audit.

So if you would like, either for the record, or Mr. Mayne can list for you all of the various evaluative criteria we employ, we can do it. Those generally are our mechanisms, sir.

Mr. FOUNTAIN. Do you have that outline, those criteria, which you can submit for the record?

Mr. NAUGHTON. We already have that.

In that connection, one of the criteria used is the unit cost which is computed by dividing the number of bills handled into the total administrative cost for a particular plan or commercial firm, and which gives you a figure of so much per bill handled.

I have that data here for part A, for fiscal year 1969, and you can check me if I am wrong.

It appears that in Portland, Maine, this appears to be about the lowest—it costs an average of $1.79 for each bill handled.

Chapel Hill, N.C., which was mentioned earlier, has an average of $3.66. But the highest figure, and this appears to be the national high, is right here in Washington, D.C., where it is indicated that it costs $5.56 per bill handled, which is substantially more than Chapel Hill, and three times Portland, Maine.

Mr. MAYNE. Are you dealing with fiscal 1969 or the first fiscal quarter of 1970?

Mr. NAUGHTON. Fiscal 1969. In view of our local plan's standing on your list, have you made any iquiry to determine why it apparently costs so much more in Washington to handle a bill than in Portland?

Mr. MAYNE. We certainly have. Over the last 18 months we have

had two groups of our people in to examine the operation, particularly to focus on the matter of cost.

Some of the problems relate to the accounting and allocation methods that were used. Some of the problems relate to the use of staff, to the fact that they are in a high salary area, and that they have a very high personnel turnover.

We are still not at all satisfied of course with all of the answers. The costs are high.

Mr. NAUGHTON. I note that the average amount of salary paid by the Washington Blue Cross for fiscal 1969 is $7,806, which is about the highest that I notice, going down the list here.

Rochester, N.Y., is $8,055, but everything else seems to be lower than that, unless I missed one.

And some of them—Chattanooga, Tenn., the average is $5,175.

The figure for New York is, $7,297. And Washington is $7,806.

I don't think anybody would claim that Washington is a low-cost-of-living area, but it certainly is not generally regarded as being as high as New York City.

What do you think is the reason for the high turnover in view of the high average salary?

Mr. MAYNE. Well, unfortunately, I guess the competition they are getting from the Federal Government as far as employment is concerned.

And the one thing that you have to keep in mind, the salary range certainly plays its part in these costs, and they do vary from plan to plan. The salary schedule will be established by the plan's basic operation. You can't very well operate an organization and have one scale of salaries for people who are working in medicare and have a different scale for the people that are doing the regular business.

So that the decision of an organization where they set their salary limits or their salary level will depend on the factors that they take into account for their total recruiting, total staffing operation.

And Washington has—even with the kind of salary they pay on an average—they still have had considerable turnover.

Mr. NAUGHTON. Of course the average could be somewhat misleading. Do you know how much of the high rating of Washington on this scale is accounted for by high executive salaries, and how much is attributable to relatively high salaries paid to the people who actually process the paper that comes through?

Mr. TIERNEY. We have those figures, because there has to be an allocation of all overhead and administration. We can get them for you.

(The following data was subsequently supplied:)

Washington, D.C. Blue Cross reported 1.3 man-years of executive salaries in fiscal year 1969 at a total salary cost of $22,765. This calculates to an average salary of $17,512, which is reasonably in line with executive salaries in other high-cost labor areas. Of the total unit cost of $5.56 for Washington, D.C. Blue Cross in fiscal year 1969, $0.63 is due to higher-than-average salaries as compared with all part A intermediaries as a group. This difference breaks down into (1) $0.10 for executive and (2) $0.53 for clerical, semiprofessional, and all other.

Mr. TIERNEY. One other thing to take into consideration on this average salary is the degree of computerization in an operation. If you have a very high level of computerization, your average salary

amounts tend to be lower. If you will notice that productivity per man-year in New York is substantially in excess of that in Washington—it is, 2,115 as against 1,849. Washington does have very largely a manual operation, and therefore has more people employed. If they had a higher level of computerization, the salary portion might go down, whereas the computer portion might go up.

Mr. Naughton. Do you think you could do it with computers in Baltimore, in the direct unit?

Mr. Tierney. I haven't any brief for the Washington, D.C., Blue Cross plan. As Mr. Mayne says, we have been aware of the fact that this has been a very high-cost operation, that it has not totally been able to utilize computers to the extent possible, and we are concerned about it.

Mr. Naughton. Do you use factors in your own direct operation that you think allow you to make economies that the Washington plan does not or cannot take advantage of? Just to get a comparison?

Mr. Tierney. I think we have a higher level of computerization that would result in a lower average manpower salary cost.

Mr. Naughton. In other words, you could probably do it cheaper?

Mr. Tierney. I would guess with you, Mr. Naughton. I don't know.

Mr. Naughton. If you can't do it cheaper than the highest cost plan on the entire list, it doesn't speak very well for your competence in your own operation.

Mr. Tierney. If we were to move into Washington, D.C., it is not just a case of plugging in the computer in Baltimore. We would have to open an office and hire people.

As a result, if our salary scale and our computerization were greater on the one hand, we would come out with a lower figure. But I haven't made an analysis to give you a yes or no answer on that.

There are many things intermediaries do besides process the bills. They are in the hospitals, they are carrying on professional relations, they are carrying on surveillance of utilization review.

We would have a problem of course of nomination. We would have to say to the Washington, D.C. hospitals, even though the law gives you a right to nominate, we are going to take it over, and this would cause problems in itself.

Mr. Fountain. Have there been instances in which intermediaries have attempted to charge cost of private business operations to the medicare program? If so, I wish you would give us the details.

Mr. Mayne. I think on that, Mr. Fountain, there certainly have been charges made, as presented on the claims for reimbursement, by the intermediaries, that have been disallowed.

In some instances, this has been a particular kind of situation—I know one was picked up by GAO in a report dealing with Aetna, where Aetna had used a flat percentage for the allocating of executive salary costs.

When this was discovered, it was corrected. Aetna said, they were wrong, it should not have been done this way and here is your money.

You might be interested in knowing that out of the 111 closing agreements for cost claims for the first year of operation, we disallowed 1.9 percent of the claimed cost.

Mr. Tierney. Cost claimed.

Mr. NAUGHTON. Of course that could mean one of two things, either that that was the percentage of ineligible costs that were claimed, which is fairly low, or that it was higher and you missed some.

Mr. MAYNE. I don't know. I think when we were before the committee the other day, we described the process of HEW audit agency, which does the audit of the intermediaries, and they take certain exceptions and then taking those exceptions, we review the situation and we make a determination then as to what should be disallowed and what may be accepted.

Mr. NAUGHTON. Did you give the figure of 1.9 percent of claimed costs disallowed?

Mr. MAYNE. 1.9 percent on the closing costs for the calendar year 1966, and then for the calendar year 1967, for those we have had closing, the figure is 1.5 percent.

Mr. NAUGHTON. What about 1968?

Mr. MAYNE. The audit agency has not completed enough of 1968 for me to have a report.

Mr. NAUGHTON. What does this 1.9 percent and 1.5 percent represent in terms of dollars?

Mr. MAYNE. The claimed costs for that 1966 year, for these 111 closing agreements, $35,608,701. And we determined that of that, $34,916,740 were allowable, or 98.1 percent of the total amount claimed.

Mr. NAUGHTON. And the amount disallowed would be $700,000 or $800,000?

Mr. MAYNE. Yes, it would be about $700,000.

Mr. NAUGHTON. How about the next year?

Mr. MAYNE. The next year, on the reports for the first 70 intermediaries and carriers, the amount claimed was $61,681,500. I do not have the closing agreements on those. That's all I have on that figure.

Mr. NAUGHTON. One and a half percent of that would be about $1 million?

Mr. MAYNE. But I can't use that figure. I am backing off because those are not all closed. We closed on 21 of that 70, so far, and for those 21, there was a total of $13,013,058 claimed, and we determined that $12,816,781 was allowable.

Mr. NAUGHTON. Do you have the books closed on administrative costs for 1966, or are there still some which have not been finally settled?

Mr. JONES. There would still be approximately 20 not settled.

Mr. NAUGHTON. So you haven't completed the accounts on administrative cost for 1966 yet?

Mr. JONES. That's correct.

Mr. NAUGHTON. The process is, I guess, that the auditors go out and examine the books and may question certain items, and recommend that they be disallowed. But does SSA then make the final determination as to whether or not to go by the auditors recommendations?

Mr. MAYNE. That is right. The auditors will set aside a certain amount for various reasons. For example, they might set aside a total amount on the subcontract because they would say the intermediary

did not come in under the terms of their contract for prior approval. This happened in that early 1966 tooling up period.

Mr. NAUGHTON. On this 1.9 percent in 1966, how does that compare with the percentage of expenditures questioned by the auditors?

Mr. MAYNE. I don't have exact parallels here. I am sorry. But the data I have in front of me deals with the 128 audits that had been made for that year, where some $43,840,000 had been audited and the auditors accepted $41½ million, or about 95 percent.

Now we still haven't settled on all of those, as you mentioned. We have a difference between 128 and 111.

Mr. NAUGHTON. For some of the items that were questioned by the auditors, this amount was cut down substantially in the later negotiations?

Mr. MAYNE. On the same basis, it was.

Mr. NAUGHTON. How long does it normally take to finally settle after an audit is made?

Mr. MAYNE. Maybe Mr. Jones could give you a better figure as an average. It is like anything else. If it comes up, as it does in some situations, where we actually owe them money, we settle very quickly. If you have a small amount, generally that is settled quickly—you collect it right away. Where there is a large amount or a particular point of issue, then those can drag on.

Mr. JONES. On the average, we would settle in about 3 months if there were no really serious problems in negotiations. A settlement in more difficult cases may stretch to 6 months or a year.

Mr. NAUGHTON. What is the general lag in the time it takes to audit the intermediaries' books after the reporting period? In other words, your audits for 1968 are not yet completed, is that correct?

Mr. JONES. The audits are made by HEW audit. It depends on manpower. They tried to audit as promptly as possible on the first go-around. On the second and third round, they have different priorities to work with. The second and third rounds have not proceeded as rapidly as the first round.

Mr. NAUGHTON. What percentage of 1968 audits are completed, for example?

Mr. JONES. For 1968, we have only received two reports as of now. There are a number of other audits now in progress.

Mr. NAUGHTON. Of course, since this is for the calendar year, they couldn't start those until 1969.

Mr. JONES. That is right.

Mr. NAUGHTON. Have you received all 1967 audits or are there a number of those out?

Mr. JONES. There are 70 reports which have been received for 1967.

Mr. NAUGHTON. Out of how many?

Mr. JONES. Out of a total of 136 with the combined A and B programs.

Mr. FOUNTAIN. Mr. Naughton, do you have some other instances or facts concerning attempts to charge costs of private business operations to the medicare program?

Mr. NAUGHTON. I have a copy of a summary audit report prepared by the HEW audit agency, and submitted on June 10, 1968. This report summarizes the results of the examinations of administrative

costs claimed for periods through December 31, 1966 by 85 of the 137 fiscal intermediaries participating in the medicare program.

The 85 fiscal intermediaries claimed administrative costs totaling $26 million. For 19 of these intermediaries, with a cost of $3 million, no discrepancies were reported in the costs claimed.

With respect to 66 intermediaries, the audit reports raised questions on, or identified for SSA consideration, costs of $1,559,640 out of a total of about $23 million claimed.

The questions raised most frequently related to the allocation, allowability, or documentation in support of (1) indirect costs, (2) costs of meetings, entertainment, advertising and travel, (3) salaries and related costs, and (4) depreciation and use charges.

Some of the particular items that were questioned and that were cited as examples—examples of the worst they found, I am sure—are given. There is a comment on indirect charges which reads as follows:

> In fifty intermediaries, we noted that Medicare had been charged with costs totaling $611,507 which had been incorrectly computed or allocated or which included amounts that were allocated on questionable bases.
>
> For example, our audits of a part A intermediary and part B carrier—which, although separate legal entities, used common facilities to jointly perform their operations—showed that they had merged their medicare and complementary insurance claims processing operations without allocating any portion of the processing costs to their nonmedicare activities. Claims received from or on behalf of medicare beneficiaries who were also eligible for benefits under the fiscal intermediaries' private complementary insurance programs, were processed by the intermediaries' claims department which determined the amounts payable under each type of coverage. Notwithstanding the fact that this claims processing operation substantially benefited the fiscal intermediaries' private lines of business, the entire cost of the operation had been charged to medicare. We estimated there was an overcharge to medicare of more than $100,000 for the 6 month period involved.

Apparently they were simply using the employees for both their private business and the medicare business, and charging the entire cost to medicare. Do you happen to know what happened to that $100,000? Have you checked it?

Mr. TIERNEY. I assume we have, but I would want to check it out. I know what you are talking about. This has been a problem since the inception of the program. This problem of merging their process with our own program.

Now there are three broad categories in which these things fall. Some people have no merger. They process the medicare bill and forget it. And then they process their own bill. So we don't have this allocation problem. Some of them do it with a totally integrated program so that when the bill is introduced, it goes through the computer and it processes two checks, the medicare check and the private business check to cover the balance.

Others use a kind of combination of that where they go through the computer processing on the medicare portion, and then take the product of that and process it for the balance that they are due.

They had to go through a long range of accounting and auditing operations and negotiations to establish the type of integrated or nonintegrated system that each intermediary or carrier has.

They have all defined a system and we have defined a method of cost allocation for each system.

I will follow that one out if you would like me to, specifically.

Mr. NAUGHTON. Yes, if you would.

Mr. TIERNEY. But that has been the problem.

Mr. NAUGHTON. Am I correct that it's been your policy not to allow costs of entertainment and of first class air travel in a routine situation for reimbursement by the medicare program?

In other words, do you follow the policy generally applicable to Government employees that the Government does not pay the cost of entertainment?

Mr. TIERNEY. I think you will find in that same report, a statement of an official determination that liquor and entertainment are not covered, since they do not contribute to efficient and effective administration.

Mr. NAUGHTON. The summary of results of audit states that "During one audit we noted that the fiscal intermediary followed a general practice of allowing its employees to use first-class air accommodations without regard to the provisions of SSA's Intermediary Manual which set forth the specific circumstances under which the additional cost of first-class accommodations are allowable (for example, where less than first-class accommodations are available only during unreasonable hours or would be detrimental to the traveler's comfort or health)."

Mr. TIERNEY. We in every instance disallowed unauthorized first-class travel.

Mr. NAUGHTON. "Largely because of this general practice, the intermediary did not have any information, on a case-by-case basis, to justify the use of first-class accommodations rather than less than first class. On the basis of our computation, we questioned costs charged to medicare of $8,351 representing the difference between the cost of the first-class and less-than-first-class air accommodations. Do you know what happened to that item?

Mr. MAYNE. I don't know who the intermediary was.

Mr. NAUGHTON. I am not sure who it was either.

Mr. TIERNEY. No question about it. We would recover it.

In another instance, the report states, "we questioned costs of $8,692 which the fiscal intermediary had charged to medicare as advertising cost. Our review showed that these expenditures were used to purchase newspaper advertisements applicable to the intermediary's private lines of business. They were in no way related to the recruitment of personnel for the intermediary's medicine activities and otherwise did not meet SSA Intermediary Manual requirements for allowability."

Of course your policy is clear on that, that you don't have to advertise for people to participate in medicare and you don't pay for it.

Mr. TIERNEY. No question about it.

Mr. NAUGHTON. In another instance the auditors said "We questioned salary costs of about $14,800, after our review showed that there were no records to substantiate that the employees involved had devoted time to medicare, and our examination of personnel records and interviews with the employees indicated that they had neither been hired for nor performed work on the intermediary's medicare operations."

Of course this type of cost would be disallowed.

Mr. TIERNEY. Right.

Mr. NAUGHTON. There is another mention in here, not too large an amount, but rather interesting. An intermediary which had charged the full cost of 67 chairs at $56 each to the program—an item of $3,631. The auditors figured the reasonable cost of depreciation would be $113. These are, of course, examples of what the auditors picked up and I am sure they are not representative.

They have gone through and cited those which they felt were most deserving of special attention.

Mr. TIERNEY. I would like to make it clear for the record there is no indication that—despite the auditor's findings—they were allowed, is there, in that report?

Mr. NAUGHTON. I don't think we know yet. Mr. Mayne, or whoever has the responsibility, if you could give us information as to what happened on each of these items questioned—the report I have doesn't give the names of intermediaries but I am sure your files will disclose that information.

Mr. TIERNEY. We will be glad to do that.

(The information below was subsequently provided for the record:)

The following is a response to questions raised on the disposition of specified items of questioned costs mentioned in the DHEW Audit Agency's summary report:

1. *Advertising*—Advertising which benefits the company's regular lines of business is an unallowable cost for the medicare program. The only, advertising costs allowable under our contracts with intermediaries and carriers are advertising for (1) recruitment of personnel, (2) the procurement of scarce items and (3) the disposal of scrap or surplus materials. No unauthorized advertising has been allowed in any of the cost settlements to date.

The case cited, where an intermediary (Pennsylvania Blue Shield) had incorrectly claimed $8,692 for advertising costs, related to advertising for recruitment of personnel. However, the company had incorrectly allocated an inequitable share of the company's total recruitment costs to medicare. The company concurred with the auditor, and the entire amount of $8,692 has been refunded.

2. *First-Class Travel*—First-class air travel is unallowable except under circumstances described in the Standardized Government Travel Regulations such as, for example, non-availability of less than first-class accomodations. No unauthorized first-class air travel has been allowed in any of the cost settlements to date.

The dispute involving the first-class air travel amounting to $8,351.

This was not an actual figure but a projection based upon statistics. The actual amount involved was only $235 and the balance of $8,116 was projected. This involved a total of $20,705 in projected expenses. The total projected expenses included numerous other things other than first-class air travel. SSA has reached an agreement with Blue Cross Association on the total ($20,705) of unallowable expenses. The exact amount attributed to first-class travel cannot be obtained.

The BHI policy regarding first-class travel can be located in part I of the intermediary manual, the administrative section, section 1156. in the part A manual and section 4156 in the part B manual. Enclosed is a copy of section 1156. which is identical to section 4156.

1156. Travel costs

E. Air travel. The difference in cost between first-class air accommodations and less than first-class air accommodations is unallowable except under circumstances described in section 3.6(c)(1) in the Standardized Government Travel Regulations (revised March 1, 1965) as quoted below:

Policy. It is the policy of the Government that persons who use commercial air carriers for transportation on official business should use less-than-first-class accommodations, instead of those designated first-class, with due regard to

efficient conduct of Government business and the travelers' convenience, safety, and comfort. In view of this policy the use of first-class accommodations should be limited to the following instances:

(a) Regularly scheduled flights between authorized origin and destination points provide only first-class accommodations.

(b) Space is not available in less-than-first-class accommodations in time to carry out the purpose of the travel.

(c) An authorizing officer authorizes or approves the use of first-class accommodations as necessary for the conduct of the mission or for reasons of the traveler's health.

(d) An authorizing officer authorizes or approves the use of first-class accommodations for flights within or between foreign areas because available less costly accommodations do not provide adequate standards of sanitation, health or comfort.

Officials responsible for approving travel authorizations may not be able to anticipate circumstances which may arise while a person is traveling which necessitate the use of first-class accommodations. In such circumstances, even though the use of first-class accommodations is authorized, the traveler is responsible for using the less costly accommodations when they will meet all reasonable requirements. For audit purposes, the traveler's judgment in these instances will be considered conclusive. However, agencies may specify on travel authorizations, or other administrative directives, that the less costly accommodations be used. In that event, the traveler will be limited to the type of accommodations specified.

1. Section 3.6(c)(1) of the Standardized Government Travel Regulations is intended to apply only to direct travel charges to the agreement.

2. Where first-class air accommodations are used in lieu of less than first-class accommodations, the reason for such use should be documented on the travel authorization or other appropriate intermediary records.

3. *Complementary insurance.*—There were two instances where companies had merged their medicare and complementary insurance claims processing operation and had not properly allocated costs to their nonmedicare activities. Amounts disallowed by the HEW Audit Agency for these two companies (Boston Blue Shield and Boston Blue Cross) for the July–December 1966 period were $42,968 and $65,952, respectively.

Agreement has been reached with both companies in the amounts recommended by the HEW Audit Agency.

4. *Records not properly documented.*—The auditor questioned costs of $14,783 for one intermediary (Inter-County Hospitalization Plan, Inc.) because records were not properly documented. Subsequent review of records by the Bureau of Health Insurance showed that some of these costs were improperly claimed. However, company documentation demonstrated that costs were incurred in other areas of operations, although the precise amount of costs could not be determined because of the absence of detailed time records. Therefore, the Bureau's position was that the company should be reimbursed an amount which would be reasonable under the circumstances. Making such a determination involved a detailed review of the company records. In addition, the records of other companies handling a comparable workload were also reviewed in order to validate the reasonableness of the determination, Following such a review, the Bureau and the company negotiated a mutually acceptable settlement. The amount agreed upon was $12,223, and the remaining $2,560 has been refunded to the Bureau of Health Insurance.

5. *Purchase of chairs.*—One fiscal intermediary (Continental Casualty) purchased 67 chairs at a cost of $3,744, and charged the full amount to medicare. Since these chairs cost more than $50 each and have an "economic life" in excess of 1 year, the company should have capitalized the equipment and charged depreciation to medicare in the amount of $113. The company concurred with the auditor's recommendation, and the questioned amount of $3,631 has been refunded to the Bureau of Health Insurance.

Mr. FOUNTAIN. Mr. Tierney, I wonder if you would tell us for the record what is meant by the term "extended care" and how you decide who is eligible to receive care in the ECF under medicare and who is not eligible?

Mr. TIERNEY. Well, Mr. Chairman, the term "extended care" is a creature of the medicare law. The statute provided that not only would there be inpatient hospital care as a benefit but that there would also be a benefit available where a person required continuous skilled nursing service, in a so-called extended care facility. Now, this was quite distinct, Mr. Fountain, from the concept of nursing home care as it existed in this country prior to medicare.

Nursing home care was largely devoted to long-range chronic illness custodial type services. It was quite clear that the Congress didn't intend this be covered. What they were seeking was a continuation of the same level of skilled nursing service that a hospital would provide but hopefully in a less expensive setting.

This is an extremely difficult thing, Mr. Fountain, to determine because there are tremendous judgment factors involved in every case. But we have put out standards and criteria for determination for the intermediaries to follow in administering this benefit.

The law provides, as you know, that notwithstanding any other provision in the law, no funds may be expended from either trust fund for care which is custodial in nature. So here you have an old woman with a broken hip and she hasn't anybody at home to take care of her and she needs some help getting dressed, but other than that she has recovered. She can get around. She is no longer in need of any skilled nursing service. We don't cover that as a benefit.

Unhappily, Mr. Fountain, one of the problems in this whole area is that the judgment sometimes has to be made retroactively. This imposes a real hardship not only on the beneficiary but on the provider of the extended care facility or nursing home. We have developed all kinds of different mechanisms, hopefully to avoid this kind of retroactive denial.

We developed a so-called assurance-of-payment provision whereby if the intermediary satisfies itself that the given institution understands this basic concept, limited concept, of extended care, if its medical staff does and if the medical record supports that level of service being rendered, that it will be assured payment on cases so long as it sends in a medical information form on cases where there is some doubt as to whether or not they fully meet the qualifications of the regulation. This has helped, but it hasn't eliminated the problem.

There are only a couple of alternatives, Mr. Fountain, and they are not very acceptable alternatives to this concept. One is let's forget extended care and all the necessity of medical judgment as to whether or not there is a need for continuing skilled nursing service. Let's simply provide post hospital nursing home care.

I have very informal estimates from the actuaries that if you go that route you are going to run into costs of $3 billion a year if you are really just going to provide custodial nursing care. As you may know, under the medicaid program nursing home care is the major cost factor.

On the other hand, you certainly raise serious doubt about providing a benefit or holding out a benefit as being a part of a benefit pattern and then turning down a very large number of the cases which hopefully qualify for it.

It is complicated further, sir, by the fact that in all these instances the doctor says yes, I think this patient ought to go to this nursing home. Well, under the law, it is quite obvious again that you can't rely simply on that certification.

It is one of the intermediary functions to determine through its own medical review whether or not this actually does meet not just medical necessity or the convenience of the patient but whether or not the medical records substantiate a continuum of service of this skilled nature.

I don't suppose, Mr. Fountain, in the whole program to date at the moment—certainly not under the part A portion—we have a more troublesome area than this one. I think, not to sound presumptuous, ultimately a decision is going to have to be made as to whether old people who have social problems, living problems, are going to have some kind of a benefit made available to them quite apart from whether or not they really need skilled nursing service. To do it will be a very expensive thing.

Mr. FOUNTAIN. That would be a tremendous policy question.

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. Mr. Tierney, of course the Social Security Administration has published literature designed for circulation to medicare beneficiaries and potential medicare beneficiaries describing what the program provides.

Do you now and have you from the beginning emphasized in as strong terms as you know how to the potential recipient that medicare does not provide nursing home benefits? That extended care is what is provided and that the custodial care is not covered?

Mr. TIERNEY. I think we have tried to make it very clear in the handbooks that nursing home care is not provided and that custodial care is not provided but I think we certainly have not gotten across to the 20 million people of the country what this very sophisticated concept of extended care is.

I think, Mr. Naughton, this is a real problem. We have done a number of things. We try to continually carry on educational programs in this regard. But to try to explain it to the average beneficiary is extremely difficult.

Mr. NAUGHTON. Could you provide for the record the warnings that you have issued, the language that you used in your general circulation pamphlets, indicating any changes made in it and what your current warnings are?

Mr. TIERNEY. Yes; I would be glad to.

(Note: The material submitted is in the subcommittee files.)

Mr. FOUNTAIN. How much would it cost to circularize every potential beneficiary with a clear-cut differentiation between the various types of services?

Mr. TIERNEY. I don't think the cost would be prohibitive because for most of these 20 million people we send them a cash check every month. We could certainly prepare inserts. We tried this. The cost part isn't tough. But explaining it in a clear-cut, concise, succinct explanation you talk about is very difficult.

Mr. FOUNTAIN. Have you talked in terms of not just what is covered but what is not covered, as some of the commercial insurance policies do and hospitalization policies?

Mr. TIERNEY. I am not sure we made that clear, Mr. Fountain.

Mr. FOUNTAIN. Sometimes that approach is more effective than saying what is covered because when you deal in terms of what is covered people can of course think of all sorts of things.

Mr. TIERNEY. One of the anomalies of this situation is if you establish that one basic need then a whole regimen of things become covered. Physical therapy, speech therapy, everything you can think of is covered. But it all hinges on that one requirement, skilled nursing care. We now are preparing in the Office of Public Information of the Social Security Administration a series of radio and television and other media explanations hoping to get this story across. I don't think we should, in any way, lessen our efforts but I am afraid we are never going to really get the story across because this becomes a very subjective thing. You are an old person and you feel sick. Maybe you have five different ailments. This thing has to be an extension of the care for which you were put into the hospital. A person might have five different things he needs care for but unless it is the one he was put in the hospital for he is not eligible. So I don't know that we will ever get the story across but we certainly should try.

Mr. NAUGHTON. You have a subsidiary problem, too, in that some institutions which really are providing custodial care will crank in unneeded physical therapy and unneeded treatments in order to try to make it appear that skilled care is being rendered.

Mr. TIERNEY. Yes, sir. That is a temptation. One of the ways some ECF's have approached it is, we can prove skilled care is required by giving a lot of it.

Mr. NAUGHTON. What percentage of the care, even in an extended care facility, would actually be skilled care in a normal case? It is a very small percentage, isn't it, where you would be getting an injection or some sort of medication that required a registered nurse or a trained medical person to administer it?

Mr. TIERNEY. Well, you get all kinds of arguments about that as to what skilled nursing service is. Just turning an old person in bed, some people say takes skilled care. Particularly if it is an orthopedic case.

Mr. NAUGHTON. But you don't require that a registered nurse do that under your regulations?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. In other words, these patients have to be fed, they have to have their personal needs tended to.

Mr. TIERNEY. If that is all, then they don't qualify.

Mr. NAUGHTON. But even if they do qualify, the personal needs and the routine care, the custodial care is going to make up 90 or 96 or 98 percent of the care they receive in most cases, is it not, even if they actually are receiving skilled care which would qualify them?

Mr. TIERNEY. I don't know whether it is that percentage.

Mr. NAUGHTON. You might have a patient who requires injections three times a day for example. That may be the only skilled care they are receiving and it would qualify them, but it would constitute less than 1 percent of the actual care they are receiving.

Mr. TIERNEY. That is quite possible.

Mr. FOUNTAIN. Is it the responsibility of the intermediary to re-

ject claims by ECF's for services provided beneficiaries who won't require extended care?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. Have the percentages of rejections for this reason by different intermediaries been fairly similar or have there been some wide variations?

Mr. TIERNEY. There have been some very wide variations, Mr. Chairman, from the beginning of the program and more recently. Certainly in the beginning of the program there was a lack of nicety of this understanding on the part of everybody concerned and I am sure there were a lot of bills paid that shouldn't have been paid. As a result of our program reviews and visits to ECF's and our gradual accumulation of data, we stepped up our guidelines for intermediaries. On the things they had to evaluate in these situations and as a result, the number of denials now is at a much higher rate than it was a year ago or at the beginning of the program.

Mr. FOUNTAIN. I wonder if you would give us some idea as to how wide the variations may be, or have been.

Mr. TIERNEY. Well, here are some figures that give you an idea. From January to June 1968 the numbers denied amounted to only 1.5 percent of the admissions. From July 1968 to June 1969 that was up to 2.7 percent. From July to December 1969, on a national basis, that was up to 7.1 percent. Some of the variations between intermediaries—Blue Cross, overall, is currently denying about 8.5 percent of the cases. The commercials range from a high of 12.8 percent to a low of 1.3 percent. So there isn't uniformity. For example, that 1.3 percent intermediary is getting far fewer bills now than it did a year ago because it is established with these institutions that there is no use sending a bill for uncovered care because it won't be paid. You can't say it is because it is only 1.3 percent they are doing an ineffective job. That is about the range of it, sir, in the overall, currently somewhere in excess of, at least for the July–December 1969 period, something in excess of 7 percent of the cases are being denied. That doesn't sound too bad. Ninety-three percent are being paid. But 7 percent of 518,000 bills is a lot of people.

Mr. FOUNTAIN. Do you have any additional information?

Mr. NAUGHTON. I have some figures which are for the period January through October 1968 and during that period for all regions the total number of bills processed was 975,707 and the number of ECF denials was 6,139 which is an average of 1.7 percent for all intermediaries.

The range is very, very wide for this period. One intermediary had no rejections out of 4,411 bills. Another had five rejections out of 27,553 bills which is five one-hundredths of 1 percent. On the high side it was 31.9 percent. An intermediary denied 1,285 of 4,033 bills submitted.

I think that what Mr. Tierney says about getting tougher is quite true. It does show up. The intermediary which denied five of 27,553 bills from January through October of 1968 happens to be Masssachusetts Blue Cross and it is my understanding that in July-August 1969 they denied 240 of 4,056 bills which would be 5.9 percent. It is my further understanding that the direct reimbursement unit in the Social Security Administration has rejected at certain periods of time as high as 56 percent of the bills submitted. Here is one which I just can't understand where for the State of Missouri, the St. Louis Blue Cross proc-

essed 6,781 bills and rejected 85 which would be 1.3 percent while over in Kansas City they processed 3,265 bills and rejected 824 which is 25.2 percent in the same State. There is a very, very wide range among the intermediaries.

In April through June of 1969 the Alabama Blue Cross turned down 580 of 1,324 which would be 43.8 percent.

Mr. FOUNTAIN. Any comments on those variations. Mr. Tierney?

Mr. TIERNEY. No, only to again tell you this has been an evolutionary process. We are in the early stages. If you go back before 1968, Mr. Naughton, you find there were virtually no turn-downs. It wasn't until we called attention stringently to those requirements of the regulations that people began to really get in and take a look.

I think some have overreacted, frankly. I am afraid in some instances they are just saying we are not going to stick our neck out. We will turn them all down. I had nursing homes, ECF's from various portions of New England come to me and say look, we have nobody. That is going too far.

Mr. NAUGHTON. Certainly an intermediary which has a reputation of being fairly tough and of turning down bills which look like they shouldn't be accepted is going to wind up after a certain period of time not getting so many ineligible bills submitted. That certainly is a factor. Would you not agree that variations in the performance of different intermediaries is a far more important factor in the difference in rejection rates than variations in the number of ineligible bills being submitted?

Mr. TIERNEY. Yes, I think so, but I think you may find you don't have quite that type of variation today, although you still have considerable variation.

Mr. NAUGHTON. It has improved.

Mr. FOUNTAIN. Would you be able to submit for the record what the situation is today as compared with that?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. It would be good to have it.

(The following information was subsequently supplied:)

PERCENTAGE OF ECF BILLS DENIED FOR NONCOVERED CARE, JANUARY 1968 TO DECEMBER 1969

Intermediary	Jan. 1, 1968 to June 30, 1968	July 1, 1968 to Sept. 30, 1968[1]	Jan. 1, 1969 to June 30, 1969	July 1, 1969 to Dec. 31, 1969
BCA	1.8	2.5	6.8	9.0
Travelers	.4	.9	1.0	1.8
Mutual	2.0	.3	3.8	5.8
Aetna	1.0	1.1	1.1	8.2
Others[2]	1.7	4.1	4.6	9.3
National	1.5	1.9	4.4	7.1

[1] Data for 4th quarter of 1968 not available due to incomplete reports.
[2] Includes the following intermediaries: Kaiser, Prudential, Hamilton Life (January through June 1968 only), Intercounty, Coop de Salud de Puerto Rico, Community Health of Michigan, Nationwide, Hawaii Medical Service, and SSA.

Mr. MAYNE. If I might I would like to make one point, too, about this question of the ineligible bill which gives us real concern. You set up this pattern that bills are going to be denied with the result that a judgment is made and the patient is not admitted to the institution on the grounds that this is not going to be exended care. What

you have done then is cut off the beneficiary who has a right under the law to make a claim for this service. This is the other side of the coin that we must keep in mind.

If we are creating a situation where people not only are being denied the opportunity for the service but even a right which they have under the law to make a claim and to go through a reconsideration and appeal process, then we have a somewhat dangerous situation.

Mr. NAUGHTON. I think the point we are making is simply that these wide variations that have existed simply can't reflect variations in the number and in the type of patients coming in. It must reflect primarily variations in the performance. Some may be being too tough. Others may be being too easy. One way it is wrong for the program. The other way it is an injustice to the beneficiary.

Mr. FOUNTAIN. Any other questions?

(No response.)

Mr. FOUNTAIN. The committee stands recessed until 10 tomorrow in room 2247.

(Whereupon, at 1:10 p.m. the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, March 4, 1970.)

ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(Part 1—Medicare Program)

WEDNESDAY, MARCH 4, 1970

HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10:15 a.m. in Room 2247, Rayburn House Office Building, the Honorable L. H. Fountain (chairman of the subcommittee) presiding.

Present: Representatives L. H. Fountain and Benjamin S. Rosenthal.

Staff members present: James R. Naughton, counsel; Phil Carlson, minority counsel, and Thomas H. Saunders, minority staff.

Mr. FOUNTAIN. Let the committee come to order.

FURTHER STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, SOCIAL SECURITY ADMINISTRATION, BUREAU OF HEALTH INSURANCE; ACCOMPANIED BY ROBERT MAYNE, ASSISTANT BUREAU DIRECTOR, DIVISION OF INTERMEDIARY OPERATIONS; MORRIS OLDER, DEPUTY ASSISTANT BUREAU DIRECTOR, DIVISION OF REIMBURSEMENT; JAMES RILEY, CHIEF, COST ANALYSIS SECTION; WARREN E. SILVERMAN, STAFF MEMBER, DIVISION OF POLICY AND STANDARDS; ROBERT OULOOSIAN, SUPERVISORY CONTRACT OPERATIONS SPECIALIST, DIVISION OF INTERMEDIARY OPERATIONS; AND LAWRENCE M. SIMMS, HEW AUDIT AGENCY

Mr. TIERNEY. Mr. Chairman, I have not seen the transcript of yesterday's hearing, but in reviewing my testimony last night in response to some of Mr. Naughton's questions about the replacement of intermediaries, I think I confused carrier replacements with some intermediaries.

Mr. FOUNTAIN. You may correct it at this point if you would like.

Mr. TIERNEY. Ironically, it is the same situation; there are four intermediaries that have been terminated, and for about the same reasons. But they were not the ones that I had in mind at the time. So if I could supply that for the record, sir?

Mr. FOUNTAIN. That will be all right.

(The following data was subsequently furnished:)

Previous discussion of terminated intermediaries was confused with carrier replacements. An analysis of the circumstances surrounding termination of the two intermediaries indicated that, while they were deficient in certain measurable areas, the primary reason for their termination was attributable to a multitude of problems relating to an overall administrative inability to meet their contract responsibilities.

One of many serious problems faced by one intermediary (Hamilton Life Insurance Co.) pertained to current financing and the establishment of interim rates. On one occasion, a sample review of 20 provider files, 17 percent of the intermediary's ECF's, revealed no instance where it could be determined that the interim rate was either established or adjusted properly. In fact, it was apparent that many rates were increased solely on the basis of telephone calls or unsupported letters from ECF administrators. Also, the intermediary was totally unprepared to handle public and provider relations activities; to assist providers in the establishment and maintenance of fiscal records; to offer guidance to providers in the development of procedures relating to utilization practices; and procedures for control of bill processing and payment were either poor or nonexistent. Furthermore, the intermediary was understaffed at all but the executive levels; had a high unit cost despite understaffing; was deficient in both quality and timeliness of performance; and was experiencing financial difficulties in its private business.

The primary deficiencies of the other intermediary (New York State Department of Health) related to internal management and poor control of its workload. The intermediary had no effective bill review mechanism; was overstaffed; had insufficient controls on queries and open items; had no written guidelines for bill reviewers; and lacked management expertise as evidenced by other less significant findings of our review of its operations. Furthermore, the intermediary failed to move ahead with a provider audit program (at termination had completed only three audits) and was virtually unable to carry out necessary provider relations activities.

Due to the nature of the above related deficiencies and the unique aspects of the subject intermediaries (one served only ECF's and the other served only HHA's), there can be no meaningful and valid comparison of other intermediaries at the so-called lower end of the performance scale. At present, there are no other intermediaries with comparable problems which would prompt termination action. However, we are closely following the progress of some intermediaries whose performance is not satisfactory.

In response to a subcommittee request for further information, the following additional data was subsequently supplied:

In addition to the explanatory statement previously furnished there is provided below statistical data comparing the terminated intermediaries with the poorest performing Blue Cross plans as to workload processing and administrative cost. In workload processing the data for the last quarter the organizations served as intermediaries is presented whereas the administrative cost data for the last fiscal year is provided.

TERMINATED INTERMEDIARIES (A) JANUARY–MARCH 1968

	Weeks' work on hand	Percent of bills pending over 30 days	Percent returned because of error
National average	1.3	12.3	4.4
Hamilton Life Insurance Co	1.1	30.5	7.9
New Hampshire BC	7.6		
Rhode Island BC	4.8		
Missouri-St. Louis BC		57.1	
Puerto Rico BC		53.9	
Missouri-St. Louis BC			11.3
Puerto Rico BC			11.0

FISCAL YEAR 1968

	Percent Adm./Ben	Unit cost
National BC and Comm	1.16	$2.98
Hamilton Life Insurance Co	1.21	3.90
Wilmington, Del. BC	2.57	
Wheeling, W. Va. BC	2.46	
Washington, D.C. BC		5.92
Wheeling, W. Va. BC		4.76

TERMINATED INTERMEDIARIES (B), APRIL–JUNE 1969

	Weeks' work on hand	Percent of bills pending over 30 days	Percent returned because of error
National average	1.1	15.0	4.4
New York State Department of Heath	1.2	19.5	4.1
Illinois-Chicago BC	3.1		
Alaska BC	2.3		
Puerto Rico BC		50.0	
Illinois-Rockford BC		31.8	
Puerto Rico BC			16.0
Missouri-St. Louis BC			12.1

FISCAL YEAR 1968

	Percent Adm./Ben	Unit cost
National BC and Comm	1.15	$3.46
New York State Department of Health	6.67	2.75
Wheeling, W. Va. BC	1.96	
Baton Rouge, La. BC	1.90	
Washington, D.C. BC		5.56
Richmond, Va. BC		5.12

Mr. FOUNTAIN. As I understand it, Mr. Tierney, it is the responsibility of the intermediary to arrange for the auditing of cost reports which are submitted by the providers for medicare reimbursement; is that right?

Mr. TIERNEY. Yes, sir. One of the specific functions under the intermediary contract is to arrange to audit the cost reports submitted by providers.

Mr. FOUNTAIN. I wonder if you can tell us approximately how much of the auditing is performed by employees of the intermediaries and how much is done by outside accounting firms employed on a contract basis?

Mr. TIERNEY. I think we can give you that figure specifically, but there is a mix that I think I ought to explain, Mr. Fountain.

Originally the cost reports come into the intermediaries, the so-called desk audit is done by the intermediaries own staff people, then the field audits are largely conducted by independent auditing firms.

(The following information was subsequently supplied:)

As of January 31, 1970, the number of audits completed was 16,240. Of these, intermediaries reported that 12,108 were completed under contract with outside audit firms and the remaining 4,132 were completed by in-house audit staff.

Mr. TIERNEY. I can give you that information for the record. The very major part is done by outside auditing firms, Mr. Fountain. A few intermediaries have the in-house capacity to do it, but very few.

The information that I have here is that there are currently some 200 firms involved, with 300 contracts.

Mr. NAUGHTON. But about eight of those have the bulk of the business, do they not?

Mr. TIERNEY. Yes; I think the major accounting firms of the Nation, Arthur Anderson & Co.; Arthur Young & Co.; Ernst & Ernst; Harris, Kerr & Forster; Haskins & Sellers; Lybrand, Ross Bros. & Montgomery; Peat, Marwick, Mitchell & Co.; Price Waterhouse & Co.

Out of 10,754 audits, those firms did all but 2,974. So, quickly, that is 7,800 they did out of that.

Mr. NAUGHTON. Who, in your shop, Mr. Tierney, has primary responsibility for riding herd over the efficiency and economy of the audit work that is done?

I know that it is the responsibility of the intermediary to arrange for and directly supervise the performance of the audit work, but who in the Social Security Administration checks on the auditors?

Mr. TIERNEY. Well, our Division of Intermediary Operations, of course, checks on the intermediaries' overall functions with the auditors, and approves the subcontracts with auditors.

The Division of Reimbursement—Mr. Older is the Deputy Assistant Bureau Director—then reviews the audits once they are submitted.

But as far as approving audit subcontracts and overseeing the intermediary conduct of the audits, Mr. Mayne has primary responsibility.

Mr. FOUNTAIN. Have you made an effort to determine how the cost of having audits performed by full-time employees compares with the cost of employing outside auditors?

Mr. TIERNEY. I would ask Mr. Mayne.

Mr. MAYNE. We have made some studies, Mr. Chairman, but the data that we have is not really conclusive.

We had supposed that there would be a real saving in using the intermediaries' own audit staff, and we still think that this has some real possibility.

But the data that we have is not conclusive enough to prove whether we would really save money on this. We think we would, for several reasons.

First, the advantage to the intermediary in having a staff that is fully available and that will not be influenced by other demands for audit work which are imposed upon the outside firm, particularly at such times as the first quarter of a calender year, on up until August 15.

We think also that there would be some savings as we went down the road because there would be less likelihood then of having new people come into the operation.

This has been one of the real problems that the audit firms have faced, that they have had to add a great number of people. These have been new people. They have gotten them trained and then for other audits they have had to bring others in.

So we would like to continue, not our experimentation, but the direction of utilizing intermediary capability where they can build up this staff. This is for them a difficult job.

We started audit activity in 1967 when the audit program really got underway after a year of program operation, and the intermediaries

as a group had some 200 people available. Now we have gone up at the present time to something well over 700, so they have increased their staffs to carry on the total job.

Mr. FOUNTAIN. How extensive was this study?

Mr. MAYNE. Well, that was our problem. We felt that we had insufficient numbers to really make a judgment, and we are continuing with our study. As we get more data, then we can come up with some evaluation.

Mr. FOUNTAIN. Do you have a specific number of people who are engaged in the study or is it just everybody take a look at this and have a general discussion type of approach?

Mr. MAYNE. We have this centered in one section, yes, and the data would be flowing into that section as we continue to get information as audits are completed.

Mr. FOUNTAIN. Will that group in which you have this information centered make a recommendation after they have accumulated all of the data they need?

Mr. MAYNE. Yes. We would hope with the great number of audits being completed that we would be in a position in a few months to make some positive recommentations.

Mr. FOUNTAIN. Who is in charge of that study?

Mr. TIERNEY. Mr. Robert Ouloosian.

Mr. FOUNTAIN. Mr. Ouloosian, I wonder at this point if you would give us the benefit, in a nutshell, of anything which you might be able to tell us to supplement what Mr. Mayne has said?

Mr. OULOOSIAN. The very limited data we have does seem to lead us to believe that there would be a fairly substantial savings in using the intermediaries' own staff, just based upon such things as the average hourly rates paid by the intermediary to its personnel as contrasted with the average hourly rates we are paying under contracts.

Now this has to be looked at very carefully because we have in a number of States a large number of providers with fiscal year-ending dates occurring all about the same time.

Well, with all the fiscal year-ending dates occurring at about the same time, and the cost reports being filed at about the same time, and all the tremendous amount of work to be done all about the same time, it may be difficult for an intermediary to staff efficiently to handle this type of workload which occurs in one small part of the year. If the intermediary staffs to do the work timely, he will be overstaffed for the rest of the year, thus more than offsetting the anticipated economies.

Although, on the surface, just looking at what an intermediary pays its employees as contrasted with what an audit firm pays its employees, there are other considerations that have to go into making the final judgment.

We are continuing to gather information and we hope when we have sufficient information that we can make more conclusive recommendations.

Mr. TIERNEY. Mr. Fountain, I think there are other activities you should be aware of that perhaps attack the problem more directly.

One of the basic problems in the final analysis is with these some 10,000 cost reports of all kinds each year. We have a shortage of accountants in this Nation. The accounting firms tell us now they will

take a kid out of college with an accounting A.B. or a bachelor of science and start him at $12,000. This is pretty nice work compared to what it was a few years ago.

So we are trying to do a number of things I think may attack the problem more directly.

First of all, the adoption of a common cost report, one that would be utilized in the final analysis not only by medicare and medicaid but by Blue Cross and others. At the present time we have this duplicative system with five or six or seven different kinds of cost reports.

The Assistant Secretary Comptroller in the Department is running a pilot project on accepting certified cost reports by a competent accounting firm which has already done an audit for the institution.

We are determining which cost reports are reliable, where the data has proved out to be correct; and therefore, instead of making an annual audit, maybe only one every 3 years.

At the inception of the program we felt strongly that it was necessary, as long as these institutions were coming in and participating, that we ought to make an audit on every single one of them. That decision resulted in some anomalous situations where we, in the first period particularly, were overkilling in the way of audits. In the second periods, of course, their production picked up, and that situation was not the same.

One of the things we found we had to do in many cases was to actually establish competent bookkeeping arrangements.

So I think the common cost reports, the acceptance of certified audits, the review of audits and determinations of whether or not you have to make simply a spot check or a full audit—these things are now emerging, and hopefully will solve the problem.

Mr. NAUGHTON. Mr. Tierney, who is in charge of the study of the so-called common cost report that you mentioned. Is that Mr. Ouloosian also?

Mr. TIERNEY. Yes. But it is more in Mr. Older's office. And I might add it is not simply within the Bureau; it is a case of working with the American Hospital Association and other people to see if we cannot develop a common cost report that everybody will employ—medicare and medicaid, as I say, and hopefully other third party payers.

Mr. NAUGHTON. When did the work start on that project?

Mr. TIERNEY. It has been going on through the Association of Hospital Financial Management and representatives of our organization and other interested parties for I would say 18 months, Mr. Naughton.

Mr. NAUGHTON. I wonder, Mr. Chairman, if it might be appropriate for them to provide for the record just a brief statement of what is being done there and who is involved in it and the amount of progress they feel has been made; and also a target date, if you are able to set one, for completion?

Mr. TIERNEY. We would be very happy to.

Mr. FOUNTAIN. Are you in a position at this time to approximate a target date?

Mr. TIERNEY. I do not think we are, Mr. Chairman.

This Massachusetts experiment that I spoke about went into effect over a year ago. I would hope that within another 6 months we will have enough data to make some evaluation of how it is operating.

(The following statement was submitted for the record:)

This project is under the general jurisdiction of the DHEW Audit Agency. The draft of the combined cost report has been completed and tested in 14 hospitals in Massachusetts. The results of the test showed that the form worked out particularly well in all of the hospitals. The audit agency is presently evaluating the comments on the cost report which were submitted by several professional organizations. Upon the completion of this evaluation, DHEW Audit will discuss the implementation of this form on a national basis with SSA officials.

DHEW Audit in conjunction with the AICPA and BCA is also drafting an audit program to accommodate this common cost report form. The draft of this program should be completed sometime in the near future.

Mr. FOUNTAIN. Are intermediaries required to secure prior approval of contracts with outside auditors?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. Have there been some occasions when this has not been done?

Mr. TIERNEY. Yes, I think that there have been.

Mr. Mayne talked about some of them yesterday who went ahead, and on the basis of their own judgment, signed contracts with auditing firms and began work prior to our approval.

Mr. NAUGHTON. Mr. Tierney, who were these intermediaries who went ahead and signed contracts without approval?

Mr. TIERNEY. I would have to ask Mr. Mayne if he has that data.

Mr. FOUNTAIN. Mr. Mayne, do you have that information?

Mr. MAYNE. I would have to give you the names. There were several Blue Cross plans, and as we discussed it yesterday, they were told to go ahead, or BCA instructed them to go ahead and complete the audits, or the audit subcontracts.

We related yesterday when this came to our attention we required that this be rescinded.

I might say that to the best of my recollection all of these were firms that had been used in the past, and there was the pressure to get the audits underway. But we insisted that this was not sufficient cause to ignore the requirements for audit subcontract approval.

The following information was subsequently provided:)

The following five Blue Cross plans were advised by BCA to proceed with audit work even though the audit subcontracts were not yet approved by the Bureau of Health Insurance:

Michigan Hospital Service
Blue Cross of South Carolina
Associated Hospital Service of Maine
Capital Blue Cross of Pennsylvania
Oregon Blue Cross

Mr. NAUGHTON. Blue Cross Association in effect told their member plans to disregard your instructions that these audit subcontracts would have to have prior approval?

Mr. MAYNE. Well, several member plans. I would not want it to appear that they made a general proclamation to all of their member plans.

Mr. NAUGHTON. Just those that inquired?

Mr. MAYNE. There were three or four having problems in getting the audit started, and I understand they raised the question with BCA.

Mr. NAUGHTON. When did it take place, approximately?

Mr. MAYNE. Approximately last June. I would have to look at the record to be sure.

Mr. NAUGHTON. What happened with respect to those not approved? Were there expenditures under the contracts when they were in a nonapproved status?

Mr. MAYNE. I do not know whether there was any work actually accomplished under the contracts before there was subsequent approval.

Mr. NAUGHTON. Did you subsequently approve them?

Mr. MAYNE. They were subsequently approved.

Mr. NAUGHTON. So all moneys spent under the contracts, whether before or after approval, were reimbursed by social security?

Mr. MAYNE. Or as the audits were going on.

Mr. NAUGHTON. Have you had any trouble with the Blue Cross or commercial intermediaries signing subsequent audit contracts without prior approval?

Mr. MAYNE. No, we have not.

Mr. FOUNTAIN. To your knowledge, what is the highest hourly rate paid to outside auditors by intermediaries and charged to the medicare program?

Mr. TIERNEY. I would have to give you the figure. It is available. I do not know what it is.

The way the contracts come in, they charge generally so much for a senior accountant per hour, a junior accountant and an apprentice, or whatever they call them.

(The following statement was supplied for the record:)

The highest hourly rate for any category of personnel in any subcontract approved by us is $50 per hour for partners of several major accounting firms. We had not approved the $53 per hour paid by the St. Louis BC Plan to Price Waterhouse which Mr. Naughton refers to on page 361 of the subcommittee hearings transcript. A sampling of approved subcontracts with the major audit firms shows that the percentage of time spent in audit activity by this most expensive category of personnel, the partner, ranges from about 1.5 to 3 percent. Thus, this high cost person constitutes only a very small part of total audit costs. We expect, from our many dealings with the major accounting firms of the country, that the hourly rates for this category of people will, for this year, range between $45 and $50 per hour.

Mr. FOUNTAIN. Can you give an example?

Mr. TIERNEY. A junior accountant, $10.50; semi-senior, at $13; a senior at $15.50; a supervisor at $20; a manager at $26; and a partner at $40.

Mr. NAUGHTON. Are those the lows?

Mr. TIERNEY. This is just an example. I would have to give you the highs.

I think you have to understand one thing: until you can really get a fix on how many hours each of these individuals operate, how many hours the senior partner is going to be involved as against the junior accountant, it is difficult to know the hourly cost of auditing.

I would like to add that on a full scope audit they use on the average 43 percent junior accountants, 23 percent semi-senior, 19 percent senior, 9 percent supervisor, 4.5 percent manager, and 1.5 percent partner. He gets in on the final act.

Mr. NAUGHTON. You indicated that only one-and-a-half percent of the hourly charges are for that most expensive category, the partner. Is this a report on the experience that you have had with all of the audits that have been conducted?

Mr. TIERNEY. No, sir. This is just an example of a cost allocation of an audit.

Mr. NAUGHTON. This represents one audit, then, does it?

Mr. TIERNEY. One audit contract.

Mr. NAUGHTON. So the fact is——

Mr. TIERNEY. If what you are seeking is what is the highest contract we have approved, we can certainly give that, but it would be on an hourly rate basis.

Mr. NAUGHTON. Then the figures you have cited do not mean a thing except that is the way the time was allocated for one contract?

Mr. TIERNEY. That is right.

Mr. NAUGHTON. Maybe you could find one where 50 percent of the time it was a partner. Would that be possible?

Mr. TIERNEY. Anything is possible. I think it would be highly improbable that a senior partner was doing 50 percent of the auditing.

And if that were so, I am sure we would raise serious questions about that kind of an audit submittal.

They do submit both; not only their cost per accountant, but their best estimate of the time spent and the best estimate of the time to be spent by each of the categories of personnel involved.

Mr. NAUGHTON. Is that an estimate of what the costs were expected to be that you have been reading to me, or is it the way the bill came in?

Mr. TIERNEY. This is an estimate of what the costs were expected to be. This was a contract. This is what they said: "Here is what we think is going to happen."

Mr. NAUGHTON. How did the charges compare with the estimate?

Mr. TIERNEY. I would have to give you the figure on that.

(NOTE.—The subcommittee was subsequently advised this information was not available.)

Mr. NAUGHTON. Maybe I should address this to Mr. Ouloosian.

Have you had any audit contracts where the actual charges turned out to be somewhat higher than the estimates?

Mr. OULOOSIAN. We have had some, yes.

Mr. NAUGHTON. What do you suppose is the highest overrun you have had in terms of the original cost estimate and the actual cost of the audit when the bill came?

Mr. OULOOSIAN. I do not have it readily available. We could secure it.

Mr. NAUGHTON. Would it exceed $100,000, do you think?

Mr. OULOOSIAN. I would not venture to say. I really do not know. I would have to get the information.

Mr. NAUGHTON. You are not sure it would not exceed $100,000?

Mr. OULOOSIAN. I am just not sure.

(The following data was later supplied:)

An analysis of 134 audit subcontracts in which original estimates were subsequently increased by amendment reflects the national figures set forth below:

Original estimates	$6,737,154
Revised estimates	$8,479,336
Dollar increase[1]	$1,742,182
Percent increase	26

[1] These are not amounts paid (many of the contracts are not completed); rather they are estimates of additional funds expected to be needed.

The largest dollar increase approved is $159,736. The average increase in the 134 subcontracts examined was approximately $12,900.

Listed below are the contracts in the sample where the increases were $25,000 or more:

Contract number	Original estimates	Revised estimates	Increase[1]	Contract number	Original estimates	Revised estimates	Increase[1]
COL 2B	$264,680	$320,335	$55,655	TEX 1	$947,010	$1,106,746	$159,736
ILC 1A	259,990	324,853	64,863	MD 1B	128,000	220,500	92,500
ILC 3A	101,191	166,098	64,907	TCH 1C	475,731	573,130	97,399
ILC 6A	238,090	273,290	35,200	FLA 15B	48,366	74,589	26,223
ILC 2A	510,673	638,035	127,362	FLA 8A	90,820	116,816	25,996
OCI 1B	109,355	156,086	46,739	MNE 1A	103,257	139,843	36,586
OCO 1A	38,700	86,408	47,708	MNE 2B	96,530	139,462	42,932
MSL 2A	239,021	271,526	32,505	GAC 2A	206,286	258,260	51,974
KAN 8A	62,335	104,375	42,040	MSL 1E	387,983	417,403	29,420
MKC 1B	113,676	149,164	35,488				

[1] These are not amounts paid (many of the contracts are not completed); rather they are estimates of addition funds expected to be needed.

Mr. TIERNEY. I think it is conceivably possible it would exceed $100,000; but I do not know, Mr. Naughton. You take an outfit that is auditing, say, all of the hospitals in New York State; they make their best estimate of what the situation is going to be; and they give you an hourly figure and an hourly breakdown. If the number of hours involved is double what they think is going to be required, it is going to amount to an awful lot of money.

Mr. FOUNTAIN. Have you taken an inventory to determine what the average hourly rate is that has been paid?

Mr. TIERNEY. The average hourly rate is somewhere around $15.

Mr. FOUNTAIN. Over the period of the operation?

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. Do you have any statistical basis for that, Mr. Tierney?

Mr. TIERNEY. Simply the audits we have in to date and what they have cost.

Mr. NAUGHTON. Who has analyzed those? Mr. Ouloosian?

Mr. TIERNEY. I think Mr. Older's division.

(The following statement was subsequently submitted for the record:)

We do not have readily available information on the average hourly audit costs paid on completed audits. To develop this data will require approximately 1 week or so of time. If it is felt that this information is that vitally necessary for the hearings, a subsequent request should be made with the understanding that considerable time and effort will be involved in pulling the data together. We do, however, have readily available the average hourly rates for audit subcontracts approved in 1969 and 1970 to date. This averages $13.14 per hour. However, as the intermediaries and audit firms implement the limited audit approach, we expect that there will be substantial reductions in the number of hours required to complete audit, but increases in the average hourly rate. This is so because in the application of a limited audit approach a greater percentage of higher level personnel is involved in the audit process. The figure of $13.14 per hour does not reflect the limited audit approach, since it is virtually impossible to estimate these in advance. What we have done to assure, however, the implementation of the limited audit approach and to bring expenditures in line with budgeted amounts is to reduce the total dollar amounts approved in proposed subcontracts by 30 percent across the board. There is no way to recalculate the average hourly rate when applying this type of an across the board reduction.

Mr. Older. We have some figures on what the cost is. Some of these figures are based on rather limited data because of the few cost reports that we have.

But, for example, in extended care facilities, on 342 audited cost reports out of 1,830, the audit costs were $501,000.

The total cost—that is, not the medicare cost, but the total costs of the institution were $89 million; and medicare costs were $18 million. The audit adjustments amounted to $419,000, so that you have the situation here—and it may be because they are first-year audits that the costs were $501,000—this is for 342 institutions—and the adjustments were $419,000.

Mr. Naughton. When you say "adjustments," Mr. Older, is that the net reduction in the amount paid on the basis of the audit as compared with the original claim? Or is it the total of adjustments both ways?

Mr. Older. I think it is the total of adjustments both ways.

Mr. Naughton. What was the net effect of those adjustments?

Mr. Older. That is the net effect. It is the net effect between the adjustments that increased costs for something the provider did not put in or decreased costs because of something put in that should not have been put in. That $419,000 is the net effect.

Mr. Naughton. Do you happen to know what the gross reductions and gross increases were?

Mr. Older. I think we can get that for you.

(The following data were supplied for the record:)

This is in reference to Mr. Naughton's request for a breakdown of the net medicare audit adjustments stated in the hearings on March 3–4. The transcript indicates that net medicare adjustments were $419,000 (rounded—$418,994). The following tabulation is an analysis of this figure.

Description of audit adjustment	Number of reports	Amount of medicare audit adjustment
No adjustments	59	0
Increase in amounts claimed	91	$323,877
Subtotal	150	323,877
Reduction in amounts claimed	191	742,871
Total	341	418,994

We do not have that on the extended care facilities. We may have some figures on hospitals for that. We can get it for you if you would like.

Mr. Naughton. Do you have available, either Mr. Ouloosian or Mr. Older, data showing for each of the audit subcontractors the amount of their estimate for audit work as compared with the amount of the bill that they sent in?

Mr. Older. I do not.

Mr. Naughton. Is this readily available?

Mr. Tierney. It is not very readily available because they do not send us a bill. They bill the intermediary and it becomes a part of its total operating expense which, at the end of the year, is again audited itself.

Now those auditing costs, the figures I gave Mr. Fountain yesterday are segregated out from their other administrative costs. So we could obtain the data for you. But it is not at present readily available.

Mr. NAUGHTON. You gave us figures for 342 audits, I believe it was, Mr. Older. Were those audits of ECF's?

Mr. OLDER. Those were ECF's.

Mr. NAUGHTON. Is that the total number of audit reports you have gotten in?

Mr. OLDER. No, we have more than that. We have 1,830.

Mr. NAUGHTON. You have 1,830 up in Baltimore?

Mr. OLDER. Yes.

Mr. NAUGHTON. What would the 342 be?

Mr. OLDER. The reason the 342 were used was these were the ones where we knew the audit costs and the audit results. On the others we did not have from the intermediaries the relative or related audit costs so we could use it as part of this sample.

Mr. NAUGHTON. What you are saying is out of 1,830 audit reports you have gotten and paid for on extended care facilities, that you only know how much it cost in 342 cases, and for the remaining 1,400-some, you do not even know how much it cost?

Mr. OLDER. Are you asking me how much it costs for audit costs?

Mr. NAUGHTON. For each of the other 1,400-some audits.

Mr. OLDER. We have total amounts, yes.

Mr. TIERNEY. I think I gave you yesterday, Mr. Naughton, the total administrative expenses and total audit costs of the intermediaries as of fiscal 1969.

To give you some feel for the scope of the audit costs, they represent somewhere between 23 and 28 percent of the total administrative costs. It is a very high percentage of the costs.

Mr. FOUNTAIN. What was the total administrative figure?

Mr. TIERNEY. Of the intermediaries, 23 to 28 percent of their total administrative costs are tied up in audit costs.

Now, this is what gives us concern, Mr. Fountain. Certainly our experience to date indicates that there is a very valid need for audits. But we certainly do not want to be guilty of overauditing; and we are trying to find mechanisms whereby we can assure that these costs that we are reimbursing to providers have actually been incurred, and yet somehow reduce this twofold thing: The very high cost of auditing and the very long process of auditing, and that is why I said we hope through the use of common audit forms and common cost reports and the rest of these things, the acceptance of certified audits, then maybe we can escape some of the costs.

But I do not think it would have been a responsible thing to do in the first years of the program.

Mr. FOUNTAIN. Mr. Mayne, would you like to add something to that?

Mr. MAYNE. I am going to move in the same direction Mr. Naughton was going, because he was raising the issue with Mr. Older as to knowledge of the audit costs for these particular situations, which is a matter then of matching the specific audit costs for the institutions where the audit has been completed.

The cost of audit goes on all the time. The payments are made by the intermediary to the audit subcontracting firms as the audits are carried on. We are apprised of these payments through the financial

reporting of the intermediaries to us; and then we do get a subsequent report when the audit operation is finally completed, which we can match then against the drawings of the intermediary, so that we do know what we are paying for audit.

But your question is: Do you know then what you spent specifically for these cost reports? And the answer is that we have not matched this up.

Mr. NAUGHTON. In other words, you know how much your total audit costs are, but, with some exceptions, you do not know how much any particular audit cost?

Mr. MAYNE. As we have explained, we know particular audit costs where we have made these studies.

Mr. NAUGHTON. Would it not be a relatively simple matter to require each auditing firm when they make an audit and turn in an audit report—I assume they turn in an audit report; maybe they do not always do that—to put on the audit report a little addendum stating how much the audit cost and what the breakdown was?

Mr. MAYNE. In effect, this is what is done on a form. It is not quite as simple, though, as it might appear to pull this data together in a big flow operation where you have the cost reports coming in one way; you have financing reporting coming in monthly; and then you would have the subsequent reporting of the actual costs of particular audits.

So I would agree this could be done but——

Mr. NAUGHTON. Let me ask you this: What percentage of the audits made of cost reports by outside auditors—in what percentage of the situations in which they charge you do they make any kind of a report at all?

Mr. MAYNE. Do they make an opinion report?

Mr. NAUGHTON. No; a report of what they found when they went to check the books to see whether the cost claim was accurate.

Mr. MAYNE. In every one of them.

Mr. NAUGHTON. You have no situations where you paid for audit work and have not received a report from an outside auditor?

Mr. TIERNEY. We may have paid on an interim basis while the audit is going on, because it is billed monthly; but the whole purpose of the audit is a certification by the auditing firm that this audit fairly represents the costs to the medicare program. So it is a full report.

Mr. NAUGHTON. And of course, the auditor, in order to turn in a bill, has to keep track of the amount of time that is used on a particular job?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. And these are firms with numbers of clients and I would assume that General Motors would be unhappy if they charged them for work done for Ford, so they must have some sort of a cost allocation of their own to enable them to tell the clients what a particular job cost?

Mr. TIERNEY. I think you are correct. It is possible, after the data is assembled, to say what the actual cost of the audit was for St. Luke's Hospital.

Mr. NAUGHTON. So they should be able to tell you what the audit cost is?

Mr. TIERNEY. I have to agree with you.

Mr. NAUGHTON. But you do not require them to simply put on the audit report that they turn in a breakdown showing how much it cost to prepare that report?

Mr. FOUNTAIN. They could probably do that in 30 minutes.

Mr. OLDER. As a practical matter, auditors do not necessarily bill immediately after a job is finished. It takes some time to prepare the report. It takes some time for the partners and others to review; and then it is the partner and the others who prepare the costs of that audit and then send out the bill.

Now what we are saying is that we have used in our sample the 342 reports in which we have been able to relate audit costs to the audit findings. There will be more and more of these as they come through, and we can add them to our study. But it is not the kind of a thing that you get automatically. As soon as an audit is completed, you don't necessarily get the related bill.

Mr. NAUGHTON. Do your regulations and the contracts that you approve require that within a reasonable time a breakdown will be provided showing the amount of costs allocated to a particular audit?

Mr. OLDER. The audit subcontract does require the audit firm to submit a final billing to the intermediary timely upon completion of the audit of a particular provider, and we do have the intermediaries reporting this information to us.

Now we get the cost reports in: and reviewing the cost reports, we find what adjustments were made by the auditors. Then as the billing information comes in, or as we can identify billings related to those audits, we will relate them and use the study to find out how much it cost us to do the audit and what we have gained from it.

Mr. NAUGHTON. Are the bills themselves required to relate the charges to particular audits?

Mr. OLDER. Yes, it would be a bill for a specific audit; as Mr. Tierney said, a bill for St. Luke's audit would be related to the St. Luke audit report.

Mr. NAUGHTON. Let me ask you this, Mr. Ouloosian——

Mr. FOUNTAIN. Before you get to that, are these bills submitted charging on the basis of fees or an hourly basis?

Mr. TIERNEY. An hourly basis.

Mr. FOUNTAIN. And they specify how many hours they were engaged in the work?

Mr. TIERNEY. That is correct.

Mr. NAUGHTON. Mr. Ouloosian, since you have the responsibility for analyzing the situation to see whether it is more economical to have auditing done by in-house auditors or some other arrangement, do you feel that you will, within a reasonable time, have satisfactory information for the cost of the remaining audits out of these 1,830 for which you have only 342 identified as to costs?

Mr. OULOOSIAN. Yes.

Mr. NAUGHTON. About what is the maximum length of time you would anticipate would intervene between the submission of the audit report and your receiving information showing you the cost of the particular audit?

Mr. OULOOSIAN. As I think Mr. Older pointed out, there seems to be

a timelag between completion of audit work and the audit firm getting around to submitting final billings.

Now, you would think offhand that since the audit firms have in every case—money coming, that they would be anxious to submit a final billing to receive their money; but that just does not seem to square off with reality. They are just not submitting final billings as promptly as we would desire.

My expectation is we will have considerable data, I would hope, in the next few months. But again, this is just an estimate off the top of my head.

Mr. NAUGHTON. How many audits would you estimate you have paid for at the present time? How many audits are supposed to have been completed of ECF's?

Mr. TIERNEY. I think Mr. Mayne has a breakdown on all audit cost reports or cost reports due, field audits completed, desk audits completed, and final settlements, and he can go through those.

Mr. NAUGHTON. As of January 1, for example, how many audits had been completed as of that time?

Mr. MAYNE. For ECF's?

Mr. NAUGHTON. Yes, for ECF's.

Mr. TIERNEY. You have information for hospitals and ECF's and home health agencies?

Mr. MAYNE. Yes, I have the whole thing.

Mr. NAUGHTON. Well, I have some figures here——

Mr. MAYNE. These columns are not typed straight; that is the trouble.

Field audits for the first year for ECF's, 582.

For the second year, 2,283.

For the third year, 847.

That was as of January 31.

Mr. NAUGHTON. So there had been about 3,600 or so audits completed as of January 1?

Mr. MAYNE. That is right. Well, January 31.

Mr. NAUGHTON. January 31, which is a solid month ago?

Mr. MAYNE. Yes.

Mr. NAUGHTON. And you have received 1,830 of those?

Mr. MAYNE. Remember, you have a final settlement to make. The fact that the audit is completed does not mean that the matter is disposed of. Once the audit is completed, the auditor may leave the shop. He may write back to the provider and say, "Now we need this kind of information in addition. We have completed the audit, but these things must be brought in. We must have this additional information."

Or, at the completion of the audit, he will give them a copy and say, "Now, these adjustments need to be made."

So this takes time.

Then after that occurs, then there must be a negotiation, if you would call it that, in broad terms, dealing with the final settlement. And this is the basic responsibility, of course, of the intermediary. And it is after the final settlement that the thing is closed out and then the cost reports, the audited cost reports would flow on into us.

So there is quite a lag.

We arranged at the outset—and sometimes I wonder whether we were really wise in doing this—to get unaudited cost reports so that

we would know what was going on. We still provide for obtaining the unaudited cost reports for extended care facilities.

I say I have some question because there has been some misreading of the unaudited cost reports and the data from them.

Mr. NAUGHTON. Perhaps this would be a good point to get in the record, the whole picture as to the delays in obtaining cost reports and in making the audits?

Mr. FOUNTAIN. All right.

Mr. NAUGHTON. I have before me an intermediary workload and provider audit activity report for January 1970.

Now, am I correct that you have three accounting periods which are more or less complete, as I understand it? The first one was the period between July 1, 1966, and June 30, 1967. In other words, the 1967 fiscal year. And the second two are the 2 following fiscal years. So the third auditing period ended June 30, 1969, for all providers.

The reporting period for a provider would not necessarily end on June 30, am I correct on that? It could end at any time during the fiscal year?

Mr. TIERNEY. Whatever their fiscal year is.

Mr. NAUGHTON. For ECF's, since the program started in January of 1967, the first period would include only those ECF's whose accounting periods ended between January 1, 1967, when the program started, and June 30, 1967, when the first accounting period ended?

Mr. MAYNE. That is right.

Mr. NAUGHTON. For those ECF's whose fiscal period was on a calendar basis, their first report would be due during the second year, and so forth.

Now you have statistics indicating that during the first 6 months of 1967, the first accounting year, 1,171 reports were due?

Mr. TIERNEY. From ECF's?

Mr. NAUGHTON. That is right; from ECF's.

Mr. TIERNEY. That is right. The first year. And of those, 1,048 had been filed.

Mr. NAUGHTON. This is as of January 1, 1970?

Mr. TIERNEY. That is right.

Mr. NAUGHTON. How long after the close of the provider's auditing period is his cost report due?

Mr. TIERNEY. The cost report is due in 90 days, with a provision that, for extenuating circumstances, the intermediary may extend that period another 30 days.

Mr. NAUGHTON. These 1,171 cost reports that were due in the first year, which ended June 30, 1967, were those actually due by June 30 or were some of them due up to 90 days later?

Mr. TIERNEY. It would all depend on their fiscal year. ECF cost reports must cover a period of 12 months or 13 consecutive equal periods of 4 weeks. However, for its first cost report a provider may file for a period of less than 12 months, but not less than 6 months under the medicare program. Such short period reports must begin with January 1, 1967, and end on the date selected by the provider for the end of its regular reporting year. In the case of a new provider having no previous cost history, a short period report ending on the date selected for its year end and covering less than 6 months will be accepted.

Nevertheless, the figure you cited, as of January 1, 1970, 1171 cost reports were due for that first year.

Mr. NAUGHTON. Would some of these not have been due until September 30?

Mr. TIERNEY. It is possible.

Mr. NAUGHTON. But the latest period at which any of the 1,171 cost reports would have been due would have been September 30, 1967, which is almost 2½ years ago.

Mr. TIERNEY. Not September 30, 1967. September 30, 1968.

You see, the program did not start until 1967.

Mr. NAUGHTON. But some of the first cost reports would have been due in that first 6-month period. The accounting year we are talking about for these 1,171 is fiscal year 1967, which ended June 30, 1967. These 1,171 reports——

Mr. TIERNEY. You are correct.

Mr. NAUGHTON. The latest date on which any one of the 1,171 reports was originally due would have been September 30, 1967, which would be 2 years and 5 months ago. Now, although 2 years and 5 months have expired from the due date——

Mr. TIERNEY. I want to make sure we are correct on that. Mr. Naughton. I am not sure there were 1,171 cost reports due by June 30, 1967, or did you say September?

Mr. NAUGHTON. By September 30.

Mr. TIERNEY. Is that correct?

Mr. MAYNE. That is correct.

Mr. TIERNEY. In other words, there were that many outfits that had a 6-month period between January 1 when the program started——

Mr. MAYNE. There were 1,171 extended care facilities whose fiscal year-ending date occurred between January 1, 1967, and June 30, 1967. This is the point. And that is right. And so under our instructions they were called on to file a cost report, even though this would be for a very short period of time, 2 or 3 months or something like that.

Mr. NAUGHTON. Yes; it would not be a year?

Mr. MAYNE. That is right.

Mr. NAUGHTON. So 1,171 reports were due not later than September 30. Of those 1,171, if my arithmetic is correct, 123 have not yet been supplied, even though 2 years and 5 months from the due date has expired.

Now, why have they not been provided? Or why have you not obtained them?

Mr. MAYNE. I think you could ask the same question, and probably you are going to, Mr. Naughton, about the second year.

Mr. NAUGHTON. Yes.

Mr. MAYNE. So let us roll the two together. It makes it a little easier for me because I have the figures rolled together here.

Mr. NAUGHTON. There are 4,868 reports due for the second period which would have been due not later than September 30, 1968. And of that number, 3,558 have been received; is that correct?

Mr. MAYNE. No.

Mr. NAUGHTON. 4,371?

Mr. MAYNE. 4,371.

Mr. NAUGHTON. How many does that leave that are still overdue from September 30, 1968, which is 1 year and 5 months ago?

Mr. MAYNE. In fact, what we have done, Mr. Naughton, is take a look at all of the delinquent cost reports for the period through December 1968 and we find that if you add these up, there are 2,108 cost reports for ECF's that are delinquent.

Of those, we have now received 1,184.

Mr. NAUGHTON. This is since January 31?

Mr. MAYNE. Yes. This is as of the 15th of February.

Mr. NAUGHTON. Do you have any more that have become delinquent since then that would build the figure back up?

Mr. MAYNE. I do not see how we could. I do not know where they would come from.

We have therefore at this point in time 924 cost reports that are outstanding. Of those, there are 152 where the intermediary has either reduced the payment or has notified the ECF that all payments are going to be suspended within 30 days unless the cost report is received.

We have an additional 140 where the cost report is delinquent where payments have already been suspended because of failure to receive the cost report.

We have another group which would represent ECF's which have left the program either because the ECF no longer participated or there was a change in ownership, so that you are looking to a different business entity; and 177 of those have been referred to the regional office for collection action.

There are 41 others where the ECF is definitely no longer in the program, or no longer in business, and demand letters have been sent for cost reports. We will proceed through our regular channels for collection on these.

There were 27 ECF's that did not submit a cost report because they had no medicare business in the fiscal year on which a cost report was called for.

We have 23 others where the audit was started without a cost report. This leaves us then a residue of 113 which involve a whole variety of actions.

So, as far as the delinquent cost reports are concerned, this has been a real problem, and I would not want to minimize in any way the role that everyone plays in this. First, the availability of cost report forms, the procedures, the lack of accounting experience in the extended care facility area, the lack of provider capability, the efforts that the intermediaries had to make with the providers in getting them to a point where they could provide a cost report or, in many instances, using the audit itself as a means of producing a cost report. Then the additional—

Well, we are dealing with delinquent reports, so let us leave it then

right at the point of the provider, the difficulty of the provider in producing a cost report.

Mr. NAUGHTON. Mr. Chairman, I suggest we might want to put in the record the summary report which gives the status of the various cost reports and audits.

Mr. FOUNTAIN. Whose summary is that?

Mr. NAUGHTON. It was done by the Social Security Administration. And perhaps if we put these two pages in the record——

Mr. FOUNTAIN. Are you familiar with these pages, Mr. Tierney?

Mr. TIERNEY. Yes, sir.

Mr. MAYNE. Very much so.

Mr. NAUGHTON. I think they would give a pretty good picture of what the statistics are.

Mr. FOUNTAIN. They will become a part of the record.

(Appropriate pages from the January 1970 "Intermediary Workload and Provider Audit Activity Report" follow:)

B. PROVIDER AUDIT ACTIVITY

This report covers the status of the audit activity for the first, second, and third accounting periods, i.e., accounting years with closing periods between July 1, 1966, and June 30, 1967; July 1, 1967, and June 30, 1968; and July 1, 1968, and June 30, 1969, for all providers for the month of January 1970 as required by part A manual, section 2050.

A 3-month comparison of the audit activity is shown in exhibit I.

This report reflects the following national averages:

	Hospital	HHA	ECF
Percent of due cost reports filed:			
1st year	98.52	95.52	89.49
2d year	96.24	94.25	89.79
3d year	84.41	84.17	79.22
Percent of field audits started to reports filed:[1]			
1st year	93.29	79.66	82.34
2d year	76.72	68.95	75.42
3d year	35.93	36.74	44.39
Percent of field audits completed to field audits started:[1]			
1st year	94.22	95.02	85.39
2d year	88.56	93.71	81.10
3d year	71.18	88.78	61.47
Percent of final settlements made to audits completed:[1]			
1st year	70.80	56.57	53.05
2d year	42.90	48.63	55.34
3d year	21.57	37.67	45.60

[1] The number of "no audit necessary" is included with "field audits started" and "field audits completed" in order to arrive at a more accurate indication of the intermediaries' progress.

The Blue Cross plans and one commercial received all cost reports due for the first 3 accounting years. Fourteen BC plans have received all cost reports due for the first and second accounting years. One BC plan has received all cost reports due for the first and third accounting years. Twenty-eight Blue Cross plans, two commercials and SSA have received all cost reports due for the first accounting year and one BC plan and one commercial have received all cost reports due for the second accounting year.

Two Blue Cross plans and one commercial have made final settlements with all providers for the first and second accounting years.

First year: New York, N.Y.
Second year:
Jamestown, N.Y.
New York, N.Y.
Puerto Rico

EXHIBIT I.—3 MONTH'S COMPARISON OF PROVIDER AUDIT ACTIVITY

	Hospitals			HHA's			ECF's		
	November 1969	December 1969	January 1970	November 1969	December 1969	January 1970	November 1969	December 1969	January 1970
Cost reports due:									
1st year			6,820			1,452			1,171
2d year			7,035			1,688			4,868
3d year			7,104			1,788			5,526
Cost reports filed:									
1st year	6,674	6,685	6,724	1,358	1,367	1,387	1,013	1,028	1,048
2d year	6,466	6,619	6,771	1,516	1,546	1,591	4,251	4,321	4,371
3d year	5,033	5,569	5,997	1,215	1,319	1,505	3,852	4,137	4,379
Desk audits completed:									
1st year	6,515	6,587	6,583	1,276	1,297	1,312	940	960	985
2d year	5,896	6,165	6,279	1,301	1,389	1,436	3,880	3,989	4,038
3d year	3,700	4,246	4,819	912	1,046	1,161	2,691	3,022	2,396
No field audit necessary:									
1st year	134	137	152	245	241	255	121	126	155
2d year	73	79	96	179	184	203	344	354	391
3d year	35	40	47	81	95	113	231	335	348
Field audit started:									
1st year	6,074	6,105	6,121	818	830	850	743	719	708
2d year	4,847	4,971	5,099	836	856	894	3,026	3,112	2,906
3d year	1,655	1,857	2,108	339	345	440	1,301	1,473	1,596
Field audit completed:									
1st year	5,731	5,773	5,759	765	781	795	538	553	582
2d year	4,187	4,346	4,505	749	773	825	2,070	2,179	2,283
3d year	1,069	1,258	1,487	260	297	378	644	750	847
Final settlements made:									
1st year	3,890	4,025	4,185	553	567	594	347	372	391
2d year	1,612	1,789	1,974	438	464	500	1,269	1,366	1,480
3d year	238	282	331	119	148	185	391	463	545
Unaudited cost statements received by BHI–DR:									
1st year	3,188	3,214	[1] 3,123	642	814	823	698	711	722
2d year	4,312	4,558	[1] 4,494	932	948	973	3,471	3,504	3,558
3d year	2,461	3,201	[1] 3,570	812	709	116	1,946	2,176	2,462
Percent to desk audited by intermediary:									
1st year	48.93	48.79	50.17	50.31	62.76	62.72	74.25	74.06	73.29
2d year	73.13	73.93	71.57	71.63	68.25	67.75	89.45	87.84	88.11
3d year	66.51	75.38	74.08	86.38	67.78	9.99	72.31	72.0	74.69
Audited cost statements received by BHI–DR:									
1st year	2,917	3,083	[1] 3,338	348	357	387	213	240	270
2d year	1,012	1,186	[1] 1,388	270	276	307	895	1,048	1,110
3d year	115	157	[1] 200	51	55	88	284	386	450
Percent to final settlements made by intermediary:									
1st year	74.98	76.59	79.76	62.92	62.96	65.15	30.55	64.51	69.05
2d year	62.77	66.29	70.31	61.64	59.48	61.40	70.52	76.72	75.00
3d year	48.31	55.67	60.42	42.85	37.16	47.56	72.63	83.36	82.56

[1] Based on physical inventory January 1970.

Mr. TIERNEY. I would ask, Mr. Chairman, that the report that Mr. Mayne just gave on the total picture also be a part of the record.

Mr. NAUGHTON. It is in the record.

Mr. FOUNTAIN. If you have some further details, we will take the whole thing.

Mr. NAUGHTON. Would you like to prepare a supplement to this to reflect the data Mr. Mayne gave?

Mr. TIERNEY. To reflect the figures Mr. Mayne just gave you, yes.

(The following information was supplied for the record:)

Current status of delinquent ECF cost reports

Delinquent reports	2,108
Cost reports received	1,184
Cost reports outstanding	[1] 924

Providers whose cost reports not received

Payments reduced or to be suspended	[2] 154
Payments suspended	140
Referred to RO for collection action	177
Terminated	[3] 41
No medicare business in fiscal year	27
Audit started without cost report	23
Other	[4] 113

[1] 673 ECF's owe program 924 cost reports.
[2] In these cases payments have already been reduced or notice sent that payments will be suspended within 30 days.
[3] Includes providers who are no longer in the medicare program and/or no longer in business. The following types of action are being taken to obtain the cost reports: Demand letter sent or field audit started without the cost report. In other cases the cost report is expected soon.
[4] Contains a variety of actions, no one of which is of sufficient number to warrant separate tabulations.

Mr. NAUGHTON. You have indicated, Mr. Mayne, that 924 cost reports are currently delinquent. Actually, the figure as of January was 2,108, but I suspect you have been making an extra special effort to get some of these in. I know we have been talking to you.

Mr. TIERNEY. About daily.

Mr. NAUGHTON. So you have all but 924 accounted for; but there are still 924 delinquent. Can you tell us approximately how much money was paid to those 924 providers who have not filed cost reports?

Mr. TIERNEY. To clarify that figure, there are 673 institutions in that 924, so that some of them owe more than one cost report.

Mr. NAUGHTON. Do you have any with three delinquent?

Mr. MAYNE. I do not know.

Mr. TIERNEY. I do not know.

Mr. NAUGHTON. Anyhow, you have 673 providers with 924 delinquent reports, and they could not have more than three, I guess, because the program has not been going on long enough. But some of them have at least two.

Are these figures for ECF's alone? Hospitals are not included, are they?

Mr. MAYNE. ECF's alone.

Mr. NAUGHTON. The hospital figures will be included in the record, of course, but we are talking now about extended care facilities.

Is the picture about the same for hospitals? Or have they a better record on submitting cost reports? Or do you have a better record on obtaining them?

Mr. MAYNE. The record on the hospitals is better on this, as it is all the way through; and this again identifies the difference in the situation at the beginning where the hospitals, even though many of them were ill equipped, there were still more that had the capacity to produce a cost report. So again in matching figures, as of December 31, 1969, we had 540 delinquent hospital cost reports for the first two accounting periods even though there are many more of them.

Mr. TIERNEY. That is out of 7,000.

Mr. NAUGHTON. There are about 7,000 hospitals, and they would have had 7,000 the first year instead of 1,100?

Mr. MAYNE. Of those, if you are interested, we have since that date received 227, leaving us 313 outstanding. Of those, 75 payments have been reduced or suspended, or given notification of suspension. In 12 there have been actual suspensions. There are 50 that have been termi-

nated. And there were 14 that had no medicare business in the fiscal year.

There are 35 that represent governmental or all-inclusive rate structures, which present a rather unique problem of its own.

There have been 32 audits started without a cost report; so that we are left with a residue of 31 that involve a lot of minor things.

Mr. NAUGHTON. Going back now to the question, approximately how much money has been paid to the 673 providers who have the 924 delinquent cost reports?

Mr. MAYNE. I do not have that figure.

Mr. TIERNEY. I think we can develop it for you.

(The following information was subsequently provided:)

	Number of providers	Number of cost reports	Total interim payments
Payments reduced or to be suspended	152	208	$8,320,472
Payments suspended	140	225	7,564,181
Referred to RO for collection	177	219	5,246,623
Terminated	41	48	1,560,756
Audit started without cost report	23	27	897,647
Other	113	160	7,950,962
No medicare business	27	34	0
Total	673	921	31,540,641

Note: 3 additional reports were submitted prior to compilation of this data, leaving a total of 921 delinquent reports.

Mr. NAUGHTON. Has anybody ever thought it might be interesting to try to figure out how much money these folks have gotten from you? Is it a safe assumption that most of those people who are providers who have delinquent cost reports, particularly over long periods of time, probably feel that they would not get any more money if they submitted a cost report, and that in fact they may wind up having a claim made against them for a recoupment of some of the money they have already received?

It is a little like the income tax situation; is it not generally accepted that people with refunds coming get their returns in first?

Mr. TIERNEY. I always do.

(Laughter.)

Mr. TIERNEY. Mr. Naughton, one of our problems in this—and I do not mean to minimize the problem because you certainly put your finger on a serious problem—involves the whole concept of the retroactive cost reimbursement.

Mr. NAUGHTON. I do not think we have time this morning to go into that.

Mr. TIERNEY. No, I do not want to get into that.

One of the things we have asked for is authority to impose liens or otherwise attach property for cost reports. We do not have the authority. We proceed under the Federal Claims Collection Act.

Mr. NAUGHTON. You do have authority to demand cost reports and examine the reports submitted?

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. You keep a record of the money you pay out?

Mr. TIERNEY. Right.

Mr. NAUGHTON. Has anybody in your shop been assigned to try to

find out how much money has been paid to these 673 providers with 924 delinquent cost reports?

Mr. TIERNEY. We have those figures, but we would have to supply them to you. The picture changes every day, as Mr. Mayne said. Since January 1 when you asked, we have gotten in 924 of them, so as of today there may be a different figure.

Mr. NAUGHTON. How many of these 673 providers, if any, would you think have gotten a total of a million dollars?

Mr. TIERNEY. I haven't any idea.

Mr. NAUGHTON. Do you think there are any on that list that have gotten a million dollars?

Mr. TIERNEY. I would not want to say.

Mr. NAUGHTON. Who is most familiar with this situation? Whose responsibility is it to follow up on these?

Mr. TIERNEY. Well, it is the responsibility obviously—and I do not want to pass the buck—it is the responsibility of the intermediary. They are the people who have made the payments and they know how much has gone out, and they know whether or not the cost report has gone in.

Mr. NAUGHTON. Have you asked the intermediaries to supply you data as to how much money has been paid to these 673 providers? It seems to me that is a very pertinent figure.

Mr. TIERNEY. We carry on a continuing dialog with intermediaries on all of these items and try to get a fix on every one of them.

But I have difficulty in answering your question. I cannot say that at any given moment in our shop we have a tabulation of how much money has been paid to these ECF's for whom we do not have cost reports.

Now, if we can identify those ECF's, we can give you the figures.

Mr. NAUGHTON. You may recall, Mr. Tierney, I think we asked about last September for just this information.

Did that go through your shop, Mr. Mayne?

Mr. MAYNE. I do not recall. You asked for information on what?

Mr. NAUGHTON. On how much has been paid to providers with delinquent cost reports.

Mr. MAYNE. I do not recall that.

Mr. TIERNEY. Did we respond to that question?

Mr. NAUGHTON. We got a considerable volume of information, and I am sure somebody prepared it.

Mr. TIERNEY. Well, Let's see. We have a lot of people here with us.

Mr. NAUGHTON. I cannot tell you those figures.

Mr. Chairman, if you want them for the record, we will supply them.

Mr. FOUNTAIN. We would like to have them.

Mr. TIERNEY. The amount of money paid to 673 care facilities that have not filed cost reports?

Mr. NAUGHTON. I do not think you have those figures, the complete total.

Mr. TIERNEY. I am not sure we do. As I say, I believe in partial reply to your inquiry last September, we told Mr. Zlamal that it would be a case of going to the intermediaries and getting these figures.

Mr. NAUGHTON. That is right.

Mr. TIERNEY. I do not want to put words in anyone's mouth and correct me if I am wrong, but I think he said, Well, that would not be necessary at that time.

If you feel it is necessary, we will do it.

Mr. NAUGHTON. We came back later and decided it would be good to get that information, and we have information about that thick [indicating] in the office that shows a part of this.

But apparently you have been unsuccessful to date in getting information from some of the intermediaries as to how much they paid out.

Mr. TIERNEY. I am sure they have that information. And if you want it, we will get it.

Mr. FOUNTAIN. Can you put in the record, Mr. Naughton, what we did get, what we did not get, and what we need that we did not get?

Mr. NAUGHTON. Yes, we can put something in there.

Mr. FOUNTAIN. Can you orally state it? Do you recall enough about it to be able to make a general statement on the record now which they can later check on and correct if you are in error?

Mr. NAUGHTON. A request was sent out to all intermediaries to provide the information that we had requested, and a considerable amount of information did come back in. We have a good deal of information as to providers who had delinquent cost reports, some of whom had received fairly large sums of money.

Mr. TIERNEY. I think the information we secured for you—at that time there were some 2,000 delinquent cost reports, and we got information on those.

Now you are asking about how much was paid to these 673 that are left, and I do not have that information. We can get it.

Mr. NAUGHTON. Do you have information as to how much was paid to the 2,154 that you originally had?

Mr. TIERNEY. I gather you have that information, Mr. Naughton.

Mr. NAUGHTON. Most of it. It is not complete.

Mr. MAYNE. How much do you lack, Mr. Naughton? Because now Mr. Ouloosian reminds me there was a telephone sweep of the country made to contact each intermediary, reidentifying these providers, the amount of interim payment, the amount of current financing. And as I understand, this was gathered and provided.

Mr. NAUGHTON. Yes.

Mr. MAYNE. How complete or incomplete was it? Was it accelerated payment rather than current financing?

Mr. FOUNTAIN. What did you say?

Mr. MAYNE. Interim payment and accelerated payment.

Mr. NAUGHTON. We will talk with you later to negotiate what response we would like to have you make. There is a considerable amount of information but it is incomplete. Apparently you were unable as of the last time we talked with you to get that basic information from some intermediaries.

Mr. FOUNTAIN. In what respect is it incomplete?

Mr. TIERNEY. Well, I do not want to argue with you. I just think this must be some misunderstanding regarding information we were unable to get from intermediaries. We would be able to get from every intermediary what it has paid to an institution.

Mr. NAUGHTON. Would there be any of these delinquent providers, do you think, who had received in excess of $500,000?

Mr. TIERNEY. I just cannot guess with you. We are talking about 673 outfits—we will pull the data together and supply it to the record.

Mr. NAUGHTON. Is there no one in your shop, Mr. Tierney, who is assigned to policing this, to try to get the intermediaries busy, or to get busy yourselves if the intermediaries will not, to see if you can recover overpayments to these people who have not even made cost reports?

Mr. TIERNEY. We take the position where the cost report has not been filed, the entire amount paid is an overpayment. This is obviously an overstatement, but nevertheless it constitutes an overpayment. And as I think you know from your discussions with Mr. Silverman, he has responsibility for and has a great deal of data on the overpayment situations which have been identified and just where we stand on them.

If you like, he would be glad to speak to that.

Mr. NAUGHTON. Is he here?

Mr. TIERNEY. Yes; he has a patch on his head, but he is here.

Mr. NAUGHTON. I think the record should show his injury was not inflicted by a member of the subcommittee staff.

Mr. TIERNEY. I might dispute that. [Laughter.]

Mr. NAUGHTON. Would you tell us as best you can, Mr. Silverman, what is the situation with respect to these 673 providers that have the overdue delinquent cost reports, as to about how much they have gotten and what some of the largest might be, and what progress is being made toward either getting the cost reports or getting final action taken?

We have some statistics in the record already on that.

Mr. SILVERMAN. Not being here for all of these things, I do not know specifically what it is you do have in the record.

However, I would like to respond to your——

Mr. NAUGHTON. I am speaking of the statistics Mr. Mayne put in earlier today.

Mr. SILVERMAN. To your present inquiry, let me say this: We have combined the overpayment situation to include all categories of providers and situations, not just specifically those who have been delinquent in filing cost reports. We have combined that situation with the situation where providers have terminated participation in this program; and they may have filed cost reports but have failed on the basis of audit to repay the program amounts which have been determined to be overpaid.

In addition to that particular situation we have other situations which are classified as overpayments. That would include situations where, on the basis of a medical audit, it has been determined that claims have been filed and paid for noncovered services and, consequently, any amounts paid on those claims to the provider have also been determined to be overpayments and would fall within this category that I work with.

In addition to those three, the fourth category was mentioned by Mr. Mayne in relation to the fact that we have participating providers who may have filed cost reports but have failed to respond to our requests for refund of the overpaid amounts determined as a basis of audit, and therefore, the intermediary has moved forward to reduce the amount being paid on an interim basis or, in some cases, as he related to you this morning, payment has been fully suspended.

Now, basically, as of December 31, 1969, in additon to the delinquent cost report statistics, we had 993 providers who had terminated their participation in the program. Some of those providers are included in the statistics that Mr. Mayne has already quoted to you as failing to file cost reports.

In fact, I can update just a little bit by responding to another point. There are some that have failed to file at least all three cost reports. This category of termination is not strictly, as may seem to be the case, one who is no longer participating in the program. Within the category of terminations we include, as Mr. Mayne indicated, a change of ownership status, because under the provider agreement, when a facility undergoes a change of ownership, the original agreement the first owner had with the Secretary ceases to be valid and the new owner must agree to participate in this program and execute a new viable provider agreement.

Mr. NAUGHTON. At that point, in case of a change of ownership, must the new owner assume liability for any obligations of the previous owner?

Mr. SILVERMAN. No, sir. This would depend upon his agreement of sale, the contract to buy the existing facility.

There have been many cases where the new owner or the new entity has assumed all of the assets and liabilities of the previous entity and, yes, we can look to the new entity for recoupment of any overpaid amounts.

Mr. NAUGHTON. Would those be mergers primarily?

Mr. SILVERMAN. No. They could be outright sales rather than a merger or consolidation. But merger and consolidation constitute another category of terminations.

The other two major categories are voluntary or involuntary; voluntary being where the provider just does not feel it is worthwhile to continue his participation in the medicare program due to various reasons, most often the lack of medicare utilization; it just does not get enough use by medicare patients to make worthwhile maintaining the recordkeeping and all the other elements of participating in the program.

On the other hand we have involuntary terminations where it has been determined that the facility no longer meets the conditions of participating in our program, and therefore we move to terminate its participation in the program.

So those are the major categories of terminated providers: Voluntary; involuntary change of ownership; closure; consolidation or merger.

We have some, obviously, who go out of business altogether; they just close their doors.

Mr. NAUGHTON. Of the 673 providers who have delinquent cost reports, and most of whom I presume have never filed a cost report—or do you have any that filed one and then were delinquent on the second one?

Mr. SILVERMAN. Yes, sir. I would like to give you some figures, if I may.

As of December 31, 1968, there were 678 terminated ECF's. Of those 678 ECF',s we have only been able to obtain cost reports and reach a settlement on some 67 providers. So the majority of the

remaining delinquent cost reports are attributable to ECF's which have terminated for one reason or another their participation in the medicare program.

Mr. NAUGHTON. Subtracting 67 from 678, I get 611. That is not the actual number included in the 673 that are now delinquent, is it?

Mr. SILVERMAN. No, sir.

Mr. NAUGHTON. The figures you cited were for December 1969, and since that time some would have filed cost reports?

Mr. SILVERMAN. That is correct, sir.

Mr. NAUGHTON. Of the 673, according to the most recent estimate, who have delinquent cost reports, what is your best judgment as to how many of those might actually be entitled to significant additional sums of money if they were to file cost reports?

Mr. SILVERMAN. Roughly between 20 and 30 percent on an average, basing this statistic on the fact that, of the providers who have terminated their participation in the program and who have subsequently submitted cost reports that we have been able to audit, our intermediaries have informed us that in about 20 to 30 percent of the cases we have ended up making additional payments to the provider.

Mr. NAUGHTON. In how many cases have there been substantial additional payments?

Mr. SILVERMAN. It depends on what you mean by "substantial."

Mr. NAUGHTON. Over $5,000, for example.

Mr. SILVERMAN. I would have to take a guess at that because most of the figures that we have are in excess of $5,000. However, we are also aware of many cases where the payments have been as little as $600. So I would have to say that of the 20 to 30 percent where we are making additional payments, better than 50 percent of the payments would represent in excess of $5,000.

Mr. NAUGHTON. These would be fairly large providers, would they not?

Mr. SILVERMAN. If you want to consider anything over 25 beds a substantial provider, then my answer would have to be "Yes".

But the majority of providers that we are concerned with here are those which have between 25 and 75 beds. The dollar volume would depend on their medicare utilization more than the bed size.

Mr. NAUGHTON. Of course, these are the ones that eventually you have been able to get cost reports from.

Would you estimate as you get to the hard-core cases that have been delinquent for longer and longer that the percentage that have more money coming is going to decline?

Mr. SILVERMAN. I think in the hard-core cases, commonsense would say these are the people who feel they owe us money.

Mr. NAUGHTON. In other words, out of the 673, you feel it is a fairly safe assumption that the great majority probably do not have any more money coming, and most of them feel they owe you some money?

Mr. SILVERMAN. That is correct, sir.

Mr. FOUNTAIN. In some cases I imagine some of them may not be in a position to pay you back.

Mr. SILVERMAN. That is correct, yes, sir.

Mr. MAYNE. Might I interject a minute? You keep using this 673 figure. Those are the 673 extended care facilities that are delinquent?

Mr. NAUGHTON. Right.

Mr. MAYNE. They owe us 924 cost reports. Now we have taken action against a number of those, as I reported. There are 152 of them where payment has already been reduced, or they have been notified it is going to be suspended.

There are an additional 140 where we have suspended payment—the intermediary has suspended payment.

So I do not want to get this tied in with a recoupment action. Maybe some of these will be involved later on in some kind of a recovery action. It may well be, though, that of these nearly 200 institutions where payment has been reduced or suspended, that this will indeed produce the cost report.

So you are not dealing with a true delinquent figure of 673 as something that is never going to come out or have something happening on it. There is a very substantial action going on.

Now we do know out of the group of 673 there are 177 where there has been referral to the regional office for collection action; another 41 that are clearly terminated.

Now this immediately begins to move these into the channel that Mr. Silverman is talking about.

Mr. NAUGHTON. Out of those 177, how much money has been produced in collections? Have you derived one single solitary cent in collections from the 177 you have referred?

Mr. SILVERMAN. Yes, sir.

Mr. NAUGHTON. OK, how much have you received?

Mr. SILVERMAN. Rather than answer that way, let me for the purposes of giving you some idea say that we have established from the central office standpoint, not in the regions now, but in those hard-core cases where even the regional offices have been unsuccessful in establishing a repayment schedule, $435,865.00 for 16 providers.

Mr. NAUGHTON. Are those promises to pay?

Mr. SILVERMAN. Commitments. All have begun paying. Some of the payment schedules run back into 1969, and I could not give you today the exact dollar determination of how much has been repaid, but all of these providers are meeting their commitments in repayments.

Mr. NAUGHTON. That is for 16 providers?

Mr. SILVERMAN. That is correct, sir.

Mr. NAUGHTON. If you divide $435,000—did you compromise any of these?

Mr. SILVERMAN. No.

Mr. NAUGHTON. The average amount of the claim that is admitted and being paid for the 16 you have gotten action on would be somewhere between $15,000 and $20,000?

Mr. SILVERMAN. Correct, sir. But some of them are as high as $95,000, and some of them are as low as $3,300.

Mr. NAUGHTON. We have been talking about 673 providers being delinquent in reports, and it is likely, I suppose, that many of them, if not most, will wind up owing money if you catch them to get the reports, but that, as you indicated earlier, is by no means the full picture as to the number of overpayments that have been made?

Mr. SILVERMAN. That is correct, sir.

Mr. NAUGHTON. Well, you do not know how many of the 673 owe you money because you have not been able to get any information, except for a few of them?

Mr. SILVERMAN. No, sir; I would not say that. Of the 993 providers which are included in our hard-core collection cases, our terminated cases or other sundry hard-core nonresponsive providers, you cannot make that sort of a statement. We are continuously working on obtaining additional information. In fact, we were informed just Monday of this week of one case where after 2 years of frustration we have managed to secure cost reports from five associated providers who have been delinquent in filing their cost reports since the beginning of the program.

But we are continuously obtaining additional information and we have secured in total information on approximately 1,114 providers which fall into this category.

Mr. NAUGHTON. These 993 so-called hard-core cases would include, I assume, a number of the 673 who are delinquent but not all, I am sure?

Mr. SILVERMAN. That is correct, sir.

Mr. NAUGHTON. It would include others who have filed the cost reports or the audit of the cost reports indicated they had received overpayments?

Mr. SILVERMAN. Correct.

Mr. NAUGHTON. Can you give an estimation as to what the total payments to these 993 hard-core cases have been?

Mr. SILVERMAN. No. But I can give you a specific figure on approximately 223 cases where we have done some intensive study out of the 990-some.

Mr. NAUGHTON. OK.

Mr. SILVERMAN. Those providers received a total of $35 million, I believe it is.

Mr. NAUGHTON. $35 million? This is the grand total of payments made?

Mr. SILVERMAN. Total payments made to the providers, 235 providers in number. It was $34,000,745.

Mr. NAUGHTON. Have you averaged that out?

Mr. SILVERMAN. No, sir.

Mr. NAUGHTON. Of that 34, do you have estimates as to the amount of this 34—$35 million which you believe are overpayments?

Mr. SILVERMAN. No, sir. These are just total payments made to the provider. We have indications on a very small number of these cases by the intermediary as to whether or not there is an underpayment or overpayment, and the figures that the intermediaries have provided us with are so inconclusive that to give you figures would be meaningless because they do not constitute a representative number of the 235 providers.

Mr. NAUGHTON. Have you had difficulty in getting the information you needed as to payments made from the intermediaries?

Mr. SILVERMAN. No, sir.

Mr. NAUGHTON. Do you have figures as to the payments made to all 993 of the hard-core cases?

Mr. SILVERMAN. Yes, sir. In just about every case. There are several we do not have the figures on, and that is for various and sundry reasons, of allocating payments to a chain of separate owners. Some facilities have undergone more than one change of ownership, and the intermediary has been able to report a total payment but we have

not been able to break it down to segregate liability; and until we can do this, we cannot work with the figures the intermediaries provide us.

Mr. NAUGHTON. What are the largest payments you are aware of that have been made to individual providers that are in this 993 hard-core category?

Mr. SILVERMAN. We have a series of five associated homes in the State of Texas——

Mr. NAUGHTON. Is that Golden Manor?

Mr. SILVERMAN. Yes, sir; that is the Golden Manor. And I have some current information on the Golden Manor for you.

Mr. NAUGHTON. What is the situation there?

Mr. SILVERMAN. The original tally on the Golden Manor homes indicates that the facilities—there are five homes involved—received a total of $1,176,006.71 in total program payments. As of the end of January of this year, we had secured a first-cycle cost report from all five of these facilities.

Mr. NAUGHTON. For fiscal year 1967?

Mr. SILVERMAN. Correct, sir. Which resulted in a reduction of the total amount outstanding by $404,420.50.

Mr. NAUGHTON. In other words, of this——

Mr. SILVERMAN. The intermediary has received cost reports, and are in the process of auditing and settling the first accounting period.

That leaves a balance of $771,586.21 for the second period. The accountants representing the Golden Age Manor Nursing Homes have not indicated that they would file the second cycle cost reports before the first cycle has been settled. Therefore, the intermediary has referred the Golden Age Manor cases to the Bureau of Health Insurance regional office in Dallas, and the case is being referred to us for referral to GAO for collection, and we are not going to wait, until the audit is completed.

Mr. NAUGHTON. You think 2 years is enough?

Mr. SILVERMAN. There were several problems involved here, the main one being we had a change of ownership with a split of responsibility for payment, and you cannot approach it as a whole. You have to work with the individual homes. The total amount outstanding for each of the homes varies considerably.

So although we are looking at it as one package, it is really five individual cases with a lesser amount of money involved.

Mr. NAUGHTON. How did the interim payments made during the first year compare with the amounts claimed on the unaudited cost report you have received?

Mr. SILVERMAN. According to the response from the intermediary, the facility has been underpaid.

Mr. NAUGHTON. Of course, you have not audited this?

Mr. SILVERMAN. No, sir.

Mr. NAUGHTON. And you will not accept that without an audit?

Mr. SILVERMAN. That is right.

Mr. NAUGHTON. Are these facilities still participating in the program?

Mr. SILVERMAN. No, sir, these are terminated facilities.

Now let me state I do not know whether the names of the facility have changed and they have come in under another name to partici-

pate or not. That is beyond the scope of the problem that I have to deal with.

Mr. NAUGHTON. Have you made any investigation to determine what the relationship of the new owners and the old owners, if any, is, other than buyer and seller?

Mr. SILVERMAN. Oh, yes, sir.

Mr. NAUGHTON. Are they related in any way?

Mr. SILVERMAN. Not according to the information the intermediary has been able to develop.

Mr. NAUGHTON. It has been stated here that one of the devices for getting cost reports in is through a reduction in the interim rate that is paid, or a suspension of payments in the delinquent cases. Under your regulations, how long do you wait before the intermediary is supposed to reduce the interim rate because of a nonfiling of a report?

Mr. TIERNEY. A maximum of 4 months now, Mr. Naughton. That regulation was put into effect in the fall of 1969.

Mr. NAUGHTON. What was it before that time?

Mr. TIERNEY. There was no penalty provided before that time. The General Counsel's office was not sure we could impose a penalty. But we have imposed the penalty and nobody has tested it. So we are continuing with the penalty.

Mr. NAUGHTON. When you speak of "penalty," do you mean the reduction of interim payments?

There is no penalty if a man collects an overpayment from you and 3 years later you get it back; he does not even have to pay interest, does he?

Mr. TIERNEY. There is no provision for our paying interest on an underpayment and requiring interest on an overpayment.

Mr. NAUGHTON. So if he has a couple hundred thousand dollars of your money he is not entitled to, he can hold it at 7 or 8 percent and stall you off as long as he can, and it is a pretty good deal?

Mr. TIERNEY. Yes, sir. And the only mechanism, as I say, is the Federal Claims Collection Act. We make a demand, and if it is not met, we turn it over to GAO and from there it goes over to the Department of justice.

Mr. NAUGHTON. You feel you have no authority to place a penalty on these overpayments where there are flagrant delays in settling, or the information is not even filed?

Mr. TIERNEY. We have no legal authority to collect interest on an overpayment. And again, as I say, neither do we have any legal obligation to pay interest on underpayments.

Mr. NAUGHTON. You do not feel as daring about trying to place a penalty on these people for that as you do about going ahead and paying part of the cost of delivery rooms?

Mr. TIERNEY. I would be glad to reopen that discussion, if you would like to.

Mr. NAUGHTON. I am sure we will at another time.

You have not asked the Congress to change the law to give you specific authority?

Mr. TIERNEY. The Senate Finance Committee report recommends that the law be changed in that regard; and in our testimony there last week we concurred in the recommendation.

Mr. NAUGHTON. You are willing to go along with what they have recommended? You did not initiate it?

Mr. TIERNEY. Mr. Naughton, after all, this is on an estimated basis when you start the beginning of a calendar or fiscal year. There is no possible way of knowing whether interim payments are going to result in an overpayment or underpayment. You do the best job you can of estimating.

If you are going to exact interest on overpayments, it would seem only fair you would also pay interest on underpayments.

Mr. NAUGHTON. In how many instances, if any, have intermediaries failed or refused to carry out instructions to reduce or suspend interim payments to providers who were delinquent?

Mr. TIERNEY. I am not aware of any instances, Mr. Naughton.

Mr. NAUGHTON. Would you provide an answer for that to the record? Would you check and ascertain whether they have in every instance——

Mr. TIERNEY. Have you any information? If you have information, I would be glad to have it to follow up.

Mr. NAUGHTON. I have a suspicion.

(The following information was subsequently supplied:)

The results of a very recent survey show that some intermediaries have not as yet reduced or suspended interim payments on all providers who are delinquent in filing cost reports. A substantial number of these providers are now out of the medicare program and, therefore, this policy cannot be applied to them. In all other instances we are following up with our intermediaries to require that action be taken. We are not aware of any refusal by an intermediary to comply with the policy.

Further information concerning the survey, which was contained in the January 1970 "Intermediary Workload and Provider Audit Activity Report," follows:

Intermediaries were asked to submit supplemental information on their January 1970 audit activity reports, indicating the reductions and/or suspensions of interim payments they had imposed on providers which failed to file timely cost reports.

The results of the survey are shown in the following table.

	Delinquent reports			Reductions			Suspensions		
	Hospital	HHA	ECF	Hospital	HHA	ECF	Hospital	HHA	ECF
1st account paid	96	65	123	21	12	5	7	5	19
2d account paid	264	97	497	47	16	62	14	13	88
3d account paid	1,107	283	1,147	155	20	182	18	19	227

Individual reports from Blue Cross plans and intermediaries show wide variation in the degree to which reductions and suspensions are being imposed. Follow up action will be taken where it appears that I.L. No. 396 is not being appropriately applied.

Mr. MAYNE. Mr. Chairman, if I might make a point with regard to the cost report filing, the penalty, certainly we had no sanction. Early, though, we did issue instructions saying that if there are delinquent cost reports, you, the intermediary, should look to the interim rate, and if it would appear that this interim rate is out of line so that you are indeed creating an overpayment, you should at that point in time reduce the interim rate.

Now, then, we strengthened that by saying that you would do it within 30 days and would do it in a precise way. And then we took the next step, saying if this does not work, then we will take the only other recourse that the General Counsel says is available to us under the law, and that is suspend payment completely.

I think you want to recognize what this means. If you stop payment completely to the institution, it means the institution under its provider agreement still is responsible for providing services to medicare patients who are in there.

It is obvious, however, that if this suspension continues for any length of time, it is going to take the institution out of the program, that they are going to stop admitting medicare beneficiaries. This then, it seems to me, is a real threat to the institution.

Now, it is not a sanction in that you are saying, Well, we will impose this amount of money against you. But it is a very definite incentive to the institution to get the cost report in, if indeed they are going to continue in the program. And certainly in communities there will be real pressure built up if this is the institution where the medicare beneficiary is to get service and the only one that is available.

All of these things have to be brought into the picture.

Mr. NAUGHTON. I have just one question for Mr. Ouloosian before getting back to Mr. Fountain's questions.

Mr. Ouloosian, are you aware of rates being paid for outside auditors in excess of $50 an hour?

Mr. OULOOSIAN. What do you mean by rates paid? Are you talking about average hourly rates, or are you talking about some particular category, like a partner?

Mr. NAUGHTON. Partner, the highest category.

Mr. OULOOSIAN. Are you talking about our paying over $50 an hour for a partner of an audit firm?

Mr. NAUGHTON. Right.

Mr. OULOOSIAN. I just wanted to get your question straight in my mind.

I really do not know. We can check and provide that information.

Mr. NAUGHTON. I am aware of at least one instance where you paid $53.

Incidentally, on your desk reviews which we have talked about——

Mr. FOUNTAIN. Was that just a case where a man did an hour's work?

Mr. NAUGHTON. Nineteen hours.

Mr. FOUNTAIN. Continuous?

Mr. NAUGHTON. It does not show that.

Mr. OULOOSIAN. Was this in connection with one audit?

Mr. NAUGHTON. Right.

Mr. OULOOSIAN. A partner putting in 19 hours, and we paid $53?

Mr. NAUGHTON. It was under contract.

First let me ask on the desk review, is this normally performed by CPA's? When the unaudited cost reports come in to the intermediary and they perform a desk review to see that the figures are correct and do various checking that they can do without looking at the books of the provider, what level of personnel customarily performs desk reviews?

Mr. OULOOSIAN. This varies considerably, particularly with the introduction of the limited scope audit program. We have been emphasizing the limited scope approach because hopefully by this approach we will cut down on total audit costs because we will cut down considerably on field audit time. Well, as the limited scope approach is implemented, you will have more higher level people engaged in the desk review program because an effective desk review program is a necessary part of the limited audit approach. It is at that stage that the scope of audit determination will have to be made, at least primarily, before the auditors get into the provider's shop.

So the category of people conducting desk reviews has been shifting. That is, we are getting more and more higher level personnel involved in desk reviews.

The desk review program is not just an arithmetic check. As the limited scope approach is being implemented, we are shifting toward a higher level personnel conducting the desk review program.

Mr. NAUGHTON. Do you allow desk review at the present time to be contracted out to outside auditors?

Mr. OULOOSIAN. We may have some instances where this is still done; however, our policy is to have the intermediary conduct the desk review with its own personnel. Thus, there should be few intermediaries left now who are not conducting their own desk review program; and if there are a few at this point in time, we are getting them to move toward developing their own desk review capability.

Mr. NAUGHTON. Would you anticipate any intermediaries would have personnel engaged in desk review at the highest supervisory level for as much as or anywhere near $53 an hour?

Mr. TIERNEY. I would not anticipate that, Mr. Naughton.

Mr. NAUGHTON. It is my understanding that the $53 was paid—the HEW auditors made an audit of the St. Louis Blue Cross plan, and apparently that intermediary at one stage of the game contracted out their desk review to an outside auditing firm, and apparently the bill submitted included 19 hours of a partner's time at $53 for desk review.

Mr. FOUNTAIN. Was this based on an initial contract in which they stated they would charge that?

Mr. NAUGHTON. That was the bill. Whether the initial contract provided for that, I am not certain.

You might indicate for the record whether the Social Security Administration approved that subcontract in advance.

Mr. OULOOSIAN. We will provide that information.

(The following information was subsequently provided:)

We did not approve in advance subcontracts for the performance of either desk reviews or consulation regarding provider fiscal records for St. Louis Blue Cross plan. The plan itself has been performing both of these functions since March of 1968.

Mr. FOUNTAIN. Do you have any idea what the average hourly rate paid to outside auditors for medicare work is?

Mr. TIERNEY. I think we covered it to some extent, Mr. Chairman. I said that the average rate was about $15.

Mr. FOUNTAIN. I believe that is what you said.

Do you have an opinion as to what it might cost on a yearly basis for intermediaries or the Social Security Administration to hire auditors competent to perform a medicare audit?

Mr. TIERNEY. On the intermediaries I do not know. It depends again on how successful we are in limiting the scope of the audit and bringing it down.

Frankly, Mr. Chairman, we do not have in the HEW audit agency at this point anywhere near the manpower capacity that would enable us to undertake this job. The HEW audit agency does do audits of intermediaries and it does do audits of those providers who deal directly with the Social Security Administration.

I am sure you are aware of the fact that all agencies of Government have been under some stringent manpower restrictions; and it would be absolutely impossible unless those restrictions were relaxed for the Government to do it.

Mr. FOUNTAIN. And this does seem to be an area of extreme shortage, the auditors?

Mr. TIERNEY. Yes, sir.

Mr. FOUNTAIN. What is the normal salary range for HEW auditors who perform the audits for intermediaries?

Mr. TIERNEY. I think Mr. Simms from the HEW Audit Agency would have the information.

Mr. SIMMS. I will have to supply that for you. We have nine regions across the country. We have grade 12's, 13's and 14's working on audits. I would have to give that to you specifically.

Mr. NAUGHTON. What would those be in terms of annual salary, Mr. Simms?

Mr. TIERNEY. I have a little card I carry around. The grade 12 runs, Mr. Naughton, from a beginning salary of $13,300 to a top of $17,400. A grade 13 runs from $15,800 to $23,535; and a grade 14 runs from $18,500 to $24,091.

Mr. NAUGHTON. What would $15 an hour be on a 40-hour-week basis? Has anybody figured that?

Mr. TIERNEY. Somebody will, but I am not going to.

Mr. SIMMS. I do not mean to give the idea that they do all the audit work. They are usually auditors in charge. We have trainees, and we have grade 11's actually doing some of the detailed work.

Mr. NAUGHTON. You have trainees at lesser grades?

Mr. SIMMS. Yes, sir.

Mr. NAUGHTON. If my calculations are correct, $15 an hour would be $600 a week, would it not, for a 40-hour week?

Mr. TIERNEY. $31,000 a year, I am told.

Mr. NAUGHTON. I don't guess many of your auditors are paid that, do you, Mr. Simms?

Mr. SIMMS. No.

Mr. FOUNTAIN. Who audits the cost reports for those who deal directly with the Social Security Administration?

Mr. TIERNEY. The HEW audit agency.

Mr. FOUNTAIN. And the salary range is the same as you just gave me?

Mr. TIERNEY. Yes, sir.

Mr. SIMMS. That is the same.

Mr. TIERNEY. I think there is one point just for the record, Mr. Fountain, worth making perhaps, and that is that these hourly rates quoted in the contracts submitted to us are for the people involved.

Generally it does not involve clerical, overhead, administration or anything else, so that all of that is incorporated into those quotations.

Mr. FOUNTAIN. I understand that.

Mr. NAUGHTON. That St. Louis bill had $6 an hour in there for some secretarial work.

Mr. MAYNE. Mr. Naughton, so we can check this out, you say that the St. Louis audit showed that this audit firm, the CPA audit firm was used for a desk audit?

Mr. NAUGHTON. Yes. And the HEW auditors objected to that use of personnel.

Mr. MAYNE. It is my understanding they were being used for consultation and advice to the providers, to get them in a position to have appropriate accounting methods so they could produce cost reports. So I think we will want to keep this in mind.

I understand also that this was disallowed, and that we supported the disallowance.

(The following statement was subsequently provided:)

The desk review expenses referred to in the HEW Audit Report of the St. Louis BC plan's 1967 administrative costs were not set aside by the HEW auditors for SSA determination. It was the finding of the HEW auditors that these expenses had been incurred in the administration of the medicare program and that the program did directly benefit from these services. Since the Government is obligated to reimburse for the fair value of services received, where the services and costs were not previously approved the HEW auditors had to determine whether the expenses incurred were reasonable and should, therefore, be paid. Copies of the HEW Audit Report were sent to the plan and BCA simultaneous with its release to us.

In reviewing this aspect of the HEW Audit Report we generally concurred in the auditors' finding that these costs should be paid. The only aspect of these costs that were unusual was the $53 hourly rate for a partner's time. Since we had in other situations approved hourly rates of $50 for a partner's time, and since partner's time totaled only 19 hours or about 2 percent of the total number of hours used to perform desk reviews, we concluded that the HEW auditors were right in not taking an exception for a total of only $57.

Mr. NAUGHTON. I take it you had not approved the contract in advance, or otherwise you would not have disallowed it?

You have a division of the Social Security Administration that deals directly with providers who have not chosen to use either Blue Cross or a commercial firm as intermediaries?

Mr. TIERNEY. Yes, sir.

Mr. NAUGHTON. Who audits cost reports for providers who deal directly with the Social Security Administration.

Mr. TIERNEY. The HEW Audit Agency.

Mr. NAUGHTON. And the salary would be the same?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Mr. Simms, do you have any idea what the average cost of the audits you make is?

Mr. SIMMS. No, but I could supply it. Our regional people making the audit make a record of the hours, and they could average it out.

(The following information was subsequently supplied:)

DEAR MR. NAUGHTON. Reference your request for information on HEW Audit Agency cost experience for audits for medicare direct dealers and differences between audits of these entities as compared to those audited by CPA's that may have a bearing on audit costs.

To obtain the cost information you requested, we made a random selection of 60 direct dealer audits performed by the audit agency during fiscal years 1969-70. The average man-days used for these audits were then multiplied by $80, the average cost per man-day.[1] The results of this study are as follows:

Type direct dealer	Number of audits	Average man-days per audit	Average cost per audit
Hospitals:			
Beds:			
0 to 100	14	58	$4,640
100 and over	10	40	3,200
Extended care facilities	5	16	1,280
Home health agencies	7	24	1,920
Group practice prepayment plans	18	28	2,240
Combined facilities [2]	6	35	2,800

[1] $10 per hour reimbursable billing rate as authorized by BOB (includes both direct and indirect costs).
[2] Includes hospital and extended care facility combinations.

Some of the differences between audits of direct dealing providers and audits of providers dealing through intermediaries that may affect audit costs are as follows:

1. Direct dealing providers audited by the audit agency have, as a group, the least sophisticated accounting systems and records of the providers participating in the program. Direct dealers are comprised mainly of (1) comparatively small proprietary institutions who have little or no accounting expertise and (2) large government operated complexes who have had little need or incentive for cost accounting.

2. About 80 percent of the direct dealers are all-inclusive rate hospitals. This means that there are no charge schedules, only limited classification of costs, and little or no statistical information for cost finding. Determining proper reimbursement at these institutions for program services is a time-consuming and involved process.

I trust the above information will meet your needs.

Sincerely yours,

JOHN J. MALLEN,
Director, HEW Audit Agency.

Mr. NAUGHTON. They keep cost figures by job?

Mr. SIMMS. They have the hours and they could average it out.

Mr. FOUNTAIN. Do you automatically conduct a full scale audit of a cost report regardless of how small an amount is claimed, and regardless of what the cost of the audit may be?

Mr. TIERNEY. In the initial go-around we did because we thought we were dealing with a brandnew program and we thought it was worthwhile going into every single institution and finding out the condition of the accounting base and making a basic determination of their costs.

A part of this, quite frankly, was not an auditing effort but an educational effort. We were trying to tell people, "This is the kind of cost accounting you are going to have to do in order to participate in this program."

That resulted in some anomalies that I am sure your staff is aware of, where we spent as much money—or I suppose there are even cases of auditing when we paid out more on the audit than we paid out in the way of benefits.

Mr. FOUNTAIN. Is it true that in a substantial percentage of cases a determination is made that no audit is necessary?

Mr. TIERNEY. It is now true, yes, sir.

Mr. Fountain. What criteria, if any, does the intermediary use in determining whether or not an audit is necessary?

Mr. Older. Basically the results of the first year's audit; the condition of the records and the records system; the internal control that exists; so that they know that things are properly done. And the amount, of course, of medicare patients that they have had. All of these contribute to the decision as to whether there should be another full scale audit or a limited scope audit, or no audit at all, perhaps.

Mr. Fountain. Are intermediaries authorized to arrange for limited audits rather than full audits under any circumstances?

Mr. Older. Yes. The manual provided that in the first year a new provider should be fully audited so that we are aware of what the recordkeeping capability is. And subsequent to that, the intermediary is to use his judgment as to whether full audits are required or a limited audit is sufficient.

Mr. Fountain. About how much are you currently spending on an annual basis for provider audits?

Mr. Tierney. I had that figure. I think I gave it to you yesterday.

Mr. Fountain. $20 million?

Mr. Tierney. It is in excess of that.

Mr. Mayne. It was $22 million last year.

Mr. Tierney. Provider auditing in 1969 was $22,573,230.

Now, that is against a benefit payment, Mr. Fountain, of $5 billion, in round figures.

Mr. Fountain. Have you given any instructions to intermediaries with respect to avoiding excessive and unnecessary costs of auditing?

Mr. Tierney. Yes, sir, we have given a number of instructions. We have put out guidelines for determining the frequency and necessity and scope of an annual audit on provider cost reports. We have not laid down any "one-two-three" guidelines like "if it is under $5,000, forget it."

We have said that probably is a factor that you ought to consider in forgetting it. But what we have said to them is that they should use sound accounting judgment as to whether or not an audit is indicated.

Mr. Fountain. I had in mind whether you send out any periodic red flag, so to speak, a caution that they be careful about the auditing and paying excessive costs.

Mr. Tierney. Yes, sir. Mr. Mayne just shows me here that for all three periods, as against 9,400 hospital audits, we have had 1,050 limited scope audits. Among home health agencies we have had 190 limited scope audits. Among ECF's, 180 limited scope audits.

We hope that will, as Mr. Ouloosian said, increase, because as the intermediary experience with each provider forms a basis for a judgment, we hope there will be a slackening off of audits.

Mr. Fountain. When outside auditors are employed, do you require that itemized bills be submited showing the costs charged to the audit of each separate provider? I believe you went over it to some extent. We may have covered that adequately.

Mr. Tierney. I think we went through that before.

Mr. Fountain. If there is any additional information you think the record ought to have, you might supply it.

I do not believe we asked you whether or not you analyze or require intermediaries to analyze audit costs to determine how the audit costs compare with the adjustments made and with the total amount claimed by providers, did we?

Mr. TIERNEY. No, sir, I do not know if you asked that question.

Mr. FOUNTAIN. I will request that now.

Mr. TIERNEY. I am not totally sure I understand your question, Mr. Fountain.

Mr. FOUNTAIN. Do you analyze, or do you require that the intermediary analyze audit costs to determine how the audit costs compare with the adjustments made and with the total amounts claimed by the providers?

Mr. TIERNEY. Yes, that is certainly one of the factors they are to take into consideration.

I might say that on the first round of audits the recovery amounted to 1.9 percent of claimed costs.

Mr. NAUGHTON. That is on an overall basis, Mr. Tierney?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. Have you required it be done on an individual basis?

Mr. TIERNEY. It is one of the things we ask the intermediaries to use judgment on, "is the audit going to cost more than the benefits?" And, "unless you have reason to believe they are putting costs into the picture that really require substantiation, don't do an audit."

Mr. FOUNTAIN. Do you have any information as to the average cost of provider audits?

Mr. TIERNEY. Here are figures on extended care facilities' audits, again, as a sample, Mr. Chairman. The average cost per audit of extended care facilities was $1,465. For hospitals the average cost was about $2,200.

Mr. FOUNTAIN. Do you have any figures to indicate how much those providers received?

Mr. TIERNEY. Yes. In this particular sample, the total costs audited amounted to $260,000. The medicare costs audited were $53,531. The audit adjustments resulted in—on the average now—a reduction of $1,225. The total medicare audit adjustment was $418,994. But the percent of audit costs to the costs audited was 2.7 percent. That is of medicare costs audited. It was six-tenths of 1 percent of the total costs audited.

Of course, this is another part of the total auditing problem. You have got to go in first and find out the total costs of the institution, and then you start allocating those costs between medicare and nonmedicare.

Mr. Mayne gives me further information for the record: the average medicare audit adjustment was $1,225, and the average cost was $1.465; so that the actual net, if you will, audit cost was $240.

Mr. NAUGHTON. This is for the 342 we were talking about?

Mr. TIERNEY. Yes.

Mr. NAUGHTON. And you have had a total of what? Six or 7,000 cost reports filed, and you have actually gotten audit reports in that you have analyzed for 342?

Mr. TIERNEY. This is just ECF's. I am not sure, but I think they were ECF's you had inquired about at some point in time.

Mr. NAUGHTON. These were the only one you had the actual audit cost data related to the actual cost, and in order to make a comparison to see whether the cost of the audit exceeds that amount, you have that amount, or you were able to get it for only 342?

Mr. TIERNEY. I do not think so, Mr. Naughton. At least, in talking to the HEW Audit Agency, it is not the purpose of an audit to go out and recover a lot of overpayments. The purpose of the audit is to establish whether or not the costs are correct; and you could spend all of this money, and if everybody had done a perfectly adequate job of costing, you would not get a dime back out of it.

But nevertheless, I think a Government program needs to establish that the costs were incurred.

Mr. MAYNE. Mr. Chairman, might I raise one point, because of the problem we have had in the relating of the costs to the particular institution, the audit costs? I think you asked, "Do we have an indication of the costs identified for the particular institution?" And the answer to that is: Yes; that is the way the audit firm bills the intermediary. The intermediary in turn reports to us.

The problem that we have here then is associating the report of billing on a prescribed form to the cost reports as they come through. We matched the reportings from the intermediaries on completed audits, priced out by individual institution, against cost reports; and with some 619 of these reports we were able to match against 342, cost reports, and develop this information.

Mr. FOUNTAIN. Do you know how many occasions there have been, if any, in which a provider audit cost more than the amount claimed?

You have made the general statement in some instances it may. Have you taken an inventory of that?

Mr. TIERNEY. I cannot give you a figure, but I will supply it for the record.

In that case we spent $1,500 for an audit and only $800 in benefits were paid. But the following year the institution developed something like $90,000 in benefit payments.

(NOTE: SSA subsequently advised that the actual benefits paid were $11,023 rather than $90,000.)

(The following statement was supplied for the record:)

Regarding all known instances in which a provider audit cost more than the amount paid the provider by medicare.

In addition to the case of the Fitzgerald, Georgia Nursing Home (ECF) there was one other instance where a provider's audit costs exceeded that of medicare benefits paid. The specific provider is an ECF in the Allied Convalescent chain of extended care facilities. The first year of operation, the ECF furnished only 12 days of covered service at a total cost of $141. The second year, the provider furnished approximately 4,200 medicare days and the cost of service was in excess of $90,000. The cost of the audit, which was performed for the 2 years simultaneously, was $2,442.

Mr. FOUNTAIN. We found one occasion where the total payment was $400 and $1,600 was paid out on the audit.

Mr. NAUGHTON. This was a Georgia nursing home in which the total amount, as I understand it, on the unaudited cost report was $400, and the audit cost around $1,500, did it not?

Mr. Riley, do you have the data on that?

Mr. OLDER. That is the one. The medicare cost was $800. Of course, $400 of that was coinsurance.

Mr. NAUGHTON. It was paid by the medicare beneficiary himself, or chargeable to him, so the amount of the medicare benefit owed the ECF, according to the report submitted, was $400.

Mr. OLDER. And the cost of the audit was $1,775. The intermediary told us the reason for the audit was that the records were in very poor condition, and because it was the first year, they felt an audit was necessary.

Mr. NAUGHTON. Is that particular ECF still in the program?

Mr. OLDER. Yes, it is.

Mr. NAUGHTON. How much have your subsequent audits cost, or have you made any subsequent audits?

Mr. OLDER. We do not have information on subsequent audits yet.

(The following information was subsequently supplied:)

FITZGERALD, GA., NURSING HOME

For the cost reporting period ending December 31, 1968, the provider was paid $10,134. Desk review revealed an additional $180 due to the nursing home. No overpayments were made. The audit firm of Ernst and Ernst, Atlanta, Ga. estimated subsequent audit at 112 hours at a cost of $1,600. No cost report has been filed for the year ending December 31, 1969.

Mr. TIERNEY. I think, Mr. Fountain, we have said several times that we made a judgment in the beginning of this program that we were going to go out and make sure the providers had the capacity to provide cost reports, and we did this without regard—you might question our judgment—to the amount involved.

Mr. NAUGHTON. Would you still go out tomorrow and do it?

Mr. TIERNEY. Of course we would not.

Mr. NAUGHTON. How long has your policy been in effect that you would not do that?

Mr. TIERNEY. It has been in effect since at least July of 1968 when we issued the first of the guidelines to intermediaries on how to determine whether or not audits should or should not be undertaken.

Mr. NAUGHTON. When was this audit made, Mr. Riley?

Mr. TIERNEY. If it were a first-round audit, they might still have conducted it. And as Mr. Older said, the real problem was not—the real cost was not so much the auditing of the $400 as it was trying to set up a set of records.

Mr. NAUGHTON. Let me have a date, if you will, because I want to see how effective the action you took in July of 1968 has been.

Mr. TIERNEY. The 1967 audit? They still would have gone ahead and done it.

Mr. OLDER. Mr. Riley does not have the specific date.

Mr. NAUGHTON. Was it August of 1969?

Mr. RILEY. The transmittal was August of 1969, but we do not know when the field audit was conducted; and the preliminary information seems to be that it was sometime in 1968.

Mr. NAUGHTON. It took them well over a year to submit the report?

Mr. RILEY. All I am saying is that the field audit was being made sometime in 1968.

(The subcommittee was subsequently informed that the audit of the Fitzgerald, Ga., Nursing Home for the year ended 1967 was conducted by Harris, Kerr, Foster, & Co. of Atlanta, Ga. The

audit work started February 3, 1969, and was completed on February 10, 1969.)

Mr. NAUGHTON. It took from 1968 until August of 1969 for the audit firm to prepare and get through channels to you an audit of $400 in payments?

Mr. TIERNEY. If those are the dates, those are the dates.

Mr. NAUGHTON. You indicated, Mr. Tierney, that you now have a policy where you may dispense with field audits, determine that they are not necessary. How long has that been in effect?

Mr. TIERNEY. Since July of 1968.

Mr. NAUGHTON. So that policy presumably was in effect before the field work was done for this particular audit?

Mr. TIERNEY. Mr. Naughton, if it were for a first-year audit, I think the intermediary would quite appropriately say, "Fine, we will never do it again, but we will take a look at least once at every single provider."

Mr. NAUGHTON. So that is your policy?

Mr. TIERNEY. I said that was the policy from the inception, and I still think it was a sound judgment.

Mr. NAUGHTON. Can you explain what the figures mean on the exhibit that has been provided where you have a category called "No field audit necessary" and you indicate here that for the first year, which would be the initial period, that there were 155 ECF's for which you decided that no field audit was necessary?

Mr. TIERNEY. In many of those instances—and I do not know whether it is all of them—there were no medicare payments. They were certified providers. They were in the program but they had incurred no costs.

Mr. NAUGHTON. Is it true all 155 of those had no payments?

Mr. OLDER. Mr. Naughton, may I read from the issuance that went out in July of 1968? It says:

> Experience has shown that for the first year that a provider participates in the program, a complete and thorough audit as contemplated in this audit program should be made unless, for example, the intermediary has full audited data available based on cost reimbursement experience prior to Medicare and the major areas of unallowable costs, deficient records, et cetera, have been identified.

Mr. NAUGHTON. So your policy would have been, even though there was only a claim for $400. Boy, if it costs $10,000 to go out and straighten out those books, we will spend it?

Mr. TIERNEY. I think that is an overstatement, Mr. Naughton. I do not think we would have spent $10,000 going over $400 books.

Mr. NAUGHTON. $1,500 is your upper limit?

Mr. TIERNEY. I think what we are saying—you seem to feel you should allow an organization to participate in medicare and if it is not doing much, just let it go.

As I went over the first day in testimony, it is the first time an accounting mechanism of this complexity, with public funds being expended, had ever been introduced into the health field, and particularly the ECF's of this Nation, and it behooved us not only to check into the health and safety standards but also the fiscal capacities. And I think we would have been irresponsible if we would have said, "If it is less than $10,000, forget it."

Mr. NAUGHTON. Who has said that, Mr. Tierney?

Mr. TIERNEY. You picked figures out of the air. I am picking figures out of the air.

Mr. NAUGHTON. You expended $1,500?

Mr. TIERNEY. True.

Mr. NAUGHTON. And you do not know whether the home is still in the program?

Mr. OLDER. It is in the program. We just do not have the latest cost report.

Under ordinary circumstances, the intermediary would have audited the first short period and the first full period at one time. We have examples of this being done; and to me, this is the commonsense approach to it.

But there are sometimes conditions which exist—if the records were in such poor condition that even a 4-month audit was necessary, both to educate the provider as to what is required and to see what could be done about it, then it might have been the intermediary's judgment that this was necessary to audit in spite of the cost.

Now I would say that he had to use his judgment as to whether $1,500 was appropriate or not.

Mr. NAUGHTON. Mr. Chairman, it might clarify the record if I could read a couple of paragraphs from the June 28, 1968 report of the HEW audit agency in which they have some comments about provider cost reports and audits. It is fairly brief.

Mr. FOUNTAIN. Go ahead.

Mr. NAUGHTON. This is an excerpt from the June 28, 1968 HEW audit report on "Areas for Improvement in Fiscal Intermediaries' Operations" for the medicare program. It states:

> At the time of our audits, most intermediaries had not received substantial numbers of provider cost reports for review, or had not contracted for provider audits. Consequently, in most cases, we deferred looking into these activities until subsequent visits.
>
> "In two cases, however, where the intermediaries had executed audit subcontracts, we found weaknesses in the intermediaries' practices and procedures for reviewing providers' statements of reimbursable costs and for administering the contracts with the audit firms. In another case, our observations of the intermediary's administration of the audit subcontract indicated the existence of similar deficiencies. We concluded that the intermediaries had assumed little, if any, real responsibility to reasonably assure themselves that audits of providers are effectively and economically carried out; that medicare's share of audit costs is not overstated; and that, for any given provider, audit time and costs will not be expended out of proportion to the reimbursement claimed.
>
> We were particularly concerned, in view of the substantial audit costs involved, that no attempt had been made by the intermediaries to determine whether, because of relatively small medicare reimbursement involved or because of other factors, an audit of some providers may not be warranted or a less-than-full-scale audit may be indicated. Because of the likelihood that these types of weaknesses may exist at other intermediaries, we believed that SSA should review existing instructions and determine whether more definitive guidelines are needed. Action on this matter in the SSA central office has been started.

Mr. TIERNEY. I think our whole testimony this morning, Mr. Fountain, is in support of that finding by the HEW Audit Agency. That is what sponsored the issuance of guidelines. That is what sponsored the development of the limited scope audit. That is what sponsored the development of uniform recordkeeping.

Mr. FOUNTAIN. I think some of these items sound small, compared with the total program and the total amount of money involved. But I think it is all designed to help the Congress and to help the agencies

see if there may not be ways in which we can improve the entire program, the administration of the program, and maybe reduce the cost of it; and at the same time take care of the people it is supposed to be taking care of; and treat providers and intermediaries properly too, of course.

I think it is sort of a partnership operation.

Mr. TIERNEY. I totally agree with you, sir.

Mr. FOUNTAIN. I think all of these points should serve a purpose and be helpful to all involved, both the Congress and the agencies and those with whom you have to deal.

Do you place any limitation on the type and amount of expenses you will pay for audit costs in addition to the per diem or per hour, whatever it may be?

Mr. TIERNEY. You mean an overall maximum?

Mr. FOUNTAIN. Yes.

Mr. TIERNEY. No, sir, we do not have any limitation.

Mr. FOUNTAIN. We have information indicating there have been occasions when outside auditors have claimed maybe excessive or unusual expenses. I believe Mr. Naughton has an example.

Mr. NAUGHTON. This is an audit of Blue Cross of Texas, and I think Ernst & Ernst had the audit contract down there. Is it true that that is the highest in the country in terms of the audit cost? Do you have any ranking as to which firms come in with the highest charges or highest-cost audits?

Mr. TIERNEY. We have the rates quoted by every firm. Now the rates quoted are hourly rates, and therefore it is hard to equate which is the highest. It depends on how many hours they spend and what the mix of their operation is.

(The following statement was subsequently submitted for the record:)

Provider audit activity at Texas Blue Cross is not the highest in the Nation. It appears that the $1.81 in the cited report was arrived at by dividing bills processed into approved audit subcontracts. Audit costs cannot be derived in this matter. Actual audit expenditures in Texas, on a provider basis, are virtually at the national average audit costs.

While Texas may have audit contracts involving large sums, this is not related to provider audit costs. Texas has almost 700 providers to audit and all contracts are with Ernst & Ernst; therefore, the total contract price will be high but the end result has been a provider cost which compares very favorably to the average.

Mr. NAUGHTON. I make that comment because there is a contract performance review of the Texas Blue Cross, July 22 through 26, 1968, Dallas, Tex., which comments that:

Provider auditing at Texas Blue Cross, which is subcontracted to Ernst & Ernst, is far more expensive than for any other intermediary and for the same 9-month period added $1.81 to the cost of processing each bill. Factors affecting the audit costs include the number of providers served in relation to the bill workload, dispersion of providers over large service area, hence, high travel costs, audit progress made during the period considered, and lack of sophistication in cost finding techniques by many small providers.

The HEW audit agency subsequently made an audit of the intermediary and objected to some charges as being excessive. For example, an auditor whose expense voucher did not indicate he left the city in which he was employed, had lunches at $8.50 and $17.75. Another auditor claimed $35 for dinner.

Mr. TIERNEY. I am not sure we paid that. I assume when the audit agency pointed them out, they were disallowed.

Mr. NAUGHTON. You would not knowingly pay that?

Here you have an auditor with a luncheon expense of $26.40. Would you pay that if he ate it?

Mr. TIERNEY. He would have to be a very fat auditor.

Mr. NAUGHTON. Fat or not, would you pick up the tab for $26.40?

Mr. TIERNEY. No, sir.

Mr. NAUGHTON. You regard that as excessive?

Mr. TIERNEY. We certainly would.

Mr. FOUNTAIN. You do have somebody that can detect that sort of thing and disallow it?

Mr. TIERNEY. In auditing the intermediary, the HEW audit agency also audits the intermediary's audit costs, Mr. Chairman.

Mr. FOUNTAIN. The committee stands recessed, subject to the call of the Chair.

(Whereupon, at 12:35 o'clock p.m., the subcommittee was recessed. subject to the call of the Chair.)

ADMINISTRATION OF FEDERAL HEALTH BENEFIT PROGRAMS

(Part 1—Medicare Program)

WEDNESDAY, MARCH 25, 1970

HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met at 10:15 a.m. in room 2203, Rayburn House Office Building, the Honorable L. H. Fountain, chairman of the subcommittee, presiding.

Present: Representatives Clarence J. Brown and Benjamin S. Rosenthal.

Staff members present: James R. Naughton, counsel.

Mr. FOUNTAIN. The committee will come to order. Let the record show that a quorum is present.

Our hearing today is a continuation of a series of hearings we began in February concerning the administration of the medicare program. Most of our questions today will probably be devoted to the use of intermediaries in carrying out medicare operations.

We are particularly interested in the manner in which intermediaries have been carrying out their responsibilities for auditing of provider records.

We are delighted you could be with us today, Mr. Tierney. We want to make it clear, however, that we didn't want to deprive the House Ways and Means Committee of your availability this morning. That is why we coordinated with them, and I told you over the telephone that it was not necessary for you to be here today.

Mr. TIERNEY. Thank you, Mr. Chairman. That's very gracious of you.

Mr. FOUNTAIN. So please feel free to leave if you feel you should do so.

Mr. TIERNEY. Is that an invitation or a suggestion?

Mr. FOUNTAIN. No, we are delighted to have you, but when you have two places you want to be, it is difficult. But this was the only morning this week we could have a hearing, and we wanted to get in as much as we could in a limited time.

Mr. Mayne, I believe the Social Security Administration previously advised the subcommittee that the average cost for completed provider audits through September 1969 was around $2,200 for hospitals and $1,600 for extended care facilities. Is that right?

Mr. MAYNE. I had better look at the record, Mr. Chairman. I believe that is the information that we did provide, based on the data that we had. $2,198 for hospitals; $1,589 for extended care facilities.

Mr. FOUNTAIN. Recognizing that a large number of unfinished audits are not reflected in those figures, do you have any reason to believe that they are not reasonably accurate?

Mr. MAYNE. I would assume from all that we have seen that this pattern will hold. That is, the cost of audit. dealing with the first two cycle periods, will run about the same.

We had expected that we would get a decrease in audit cost after the first period because of the experience both of the provider and the audit firm. Our data is insufficient to support any conclusion in this direction.

Mr. FOUNTAIN. Have you made any attempt to determine which intermediaries are incurring the highest average cost per audit? And if you have, I wonder if you would describe any such attempt and indicate just what you found out?

Mr. MAYNE. You mean the intermediaries that have the highest cost for the conduct of their audit?

Mr. FOUNTAIN. Right.

Mr. MAYNE. We have certainly identified these from the basic contracts or subcontracts that the intermediaries have entered into with the accounting firms. A good deal of this depends on the kind of subcontract that they could get and the costs established by that contract.

Mr. NAUGHTON. Actually, Mr. Mayne, the contract may to some extent establish the cost, but it establishes the rates more than it does the cost, does it not? In other words, it fixes an hourly rate at which the auditors work, and the actual cost of the audit depends on how many hours they put in, which may or may not be the amount they originally thought would be sufficient?

Mr. MAYNE. This is true to some degree. On the other hand, we have established this as a budget figure. We identified for the second round of audit costs a reduction of some 30 percent, so that we would establish a control on the total amount of money that was expended for audit.

So the key certainly is what do you have when you get the final bill in, but if the intermediary sees that the audit costs are going to exceed the amount of the budget, then they are under instructions to come in and ask for a supplemental allotment under the budget, in order that they may carry it on.

It could well be that the estimated number of hours of audit time was inadequate. When the auditors have gone into certain providers, they have found that the condition of the records was such that it would require considerably more time than they had estimated.

Mr. FOUNTAIN. I wonder if you would indicate which of the intermediaries are showing the highest cost per audit, giving the figures as to their cost and any explanation that you may have, or any information you may have, indicating the reasons for those costs.

Mr. MAYNE. Well, we may have to supply that for the record.

(The following information was supplied for the record:)

The following 10 intermediaries have the highest audit costs for completed audits by type of provider and by fiscal year in which the costs were reported. The average audit costs for all intermediaries were $2,198 for hospitals and $1,589 for ECF's.

Intermediary	Hospitals			ECF's		
	June 30, 1968	June 30, 1969	June 30, 1970	June 30, 1968	June 30, 1969	June 30, 1970
Maryland BC			$4,263			
Connecticut BC		$3,906				
St. Louis, Mo. BC		3,840	4,093			
Kansas City, Mo. BC	$3,252	2,934	3,305			
Chicago, Ill. BC	2,783	4,585	5,548			$2,292
Idaho BC					$1,745	1,631
Kentucky BC						1,938
Indiana BC					2,056	1,933
South Carolina BC			3,077			
Travelers		2,626	2,423		1,662	2,003

On a previously prepared report audit costs data was shown by States and not intermediaries. The testimony on the next few pages is based on that report. The above data is shown by intermediary. On the previous report Idaho was incorrectly reported. This report corrects that data. Since New York City and Washington, D.C. Blue Cross plans had reported only one final billing each for completed audits, they were not considered for possible inclusion in the "high 10" because we felt that one billing could not be considered representative of their costs.

The above high costs are due to the large number of hours needed to satisfactorily complete these audits. There are a number of reasons for the large number of hours used. They include poor provider records, complex multiple facility institutions, related organization facilities, and foundation connected institutions.

Mr. FOUNTAIN. If you don't have it readily available, maybe with just a few questions we can get the summary of it, and you can supply the details for the record.

Mr. NAUGHTON. Have you made an examination of the completed audits—you don't have cost figures for very many audits as yet, but there is a fair number in total—to attempt to ascertain what the final performance record in terms of audit costs is?

In other words, what is the average cost per audit for completed audits? Which of the intermediaries are much higher than the others, or do you just not know?

Mr. MAYNE. We have the data with regard to the average costs shown on the audit billings that are received in the specific fiscal years, and from this we can identify those that have higher costs than others.

For example, we can say that there are three intermediaries whose costs are higher than most of the others.

Mr. NAUGHTON. Which ones are they?

Mr. MAYNE. Missouri——

Mr. NAUGHTON. Missouri Blue Cross?

Mr. MAYNE. Which would be the St. Louis Blue Cross.

Mr. FOUNTAIN. What are their costs?

Mr. MAYNE. Theirs for the first period was on hospitals, $3,182 average.

Mr. NAUGHTON. What are the other two?

Mr. MAYNE. The others that come close to that are South Carolina, an average of $2,590 for that first period, and they are about tied with the next one which would be New Jersey, $2,542.

Mr. NAUGHTON. To the best of your knowledge, at the present time, the three intermediaries with the highest average cost per completed audit are St. Louis Blue Cross, New Jersey, and South Carolina, and the highest of all to your knowledge is an average of about somewhat

less than $3,200 for the St. Louis Blue Cross, and the other two are about $2,500 or $2,600?

Mr. MAYNE. No. I am sorry if I misled you. I said this was for the first fiscal year.

These costs will vary as you go along.

Mr. NAUGHTON. Let me qualify my remarks by saying for the first fiscal year. Then is everything I said true?

Mr. MAYNE. Yes, rather than for the current reading. The second fiscal year, you get quite a change; in fact I see I should have had one in that was higher than South Carolina. Illinois started out with $2,783.

For the second fiscal year, your pattern changes somewhat. Illinois' costs are considerably larger on the billings that we received. This may not be indicative now of what will come in the final roundup, $4,585.

The next highest that fiscal year would be Missouri, $3,545, and number three would be Kentucky, $3,133.

Mr. NAUGHTON. Excuse me, Mr. Mayne, to save a little time, perhaps—you are reading I guess from the supplemental sheet provided to us along with the average audit cost figures?

Mr. MAYNE. Yes.

Mr. NAUGHTON. What is the highest average cost shown on that sheet for any period that you are aware of?

Mr. MAYNE. I believe it is Illinois.

Mr. NAUGHTON. For the third fiscal year period? $5,548?

Mr. MAYNE. Right.

Mr. NAUGHTON. I notice that Idaho, for the second period, had $6,084, but I don't notice anything more than that.

Mr. MAYNE. We must be looking at different sheets.

Mr. NAUGHTON. I am looking at the ECF's, on the other side of the page.

Mr. MAYNE. I thought we had been talking strictly about hospitals.

Mr. NAUGHTON. Normally you would expect hospital audits to cost more than ECF's?

Mr. MAYNE. Yes.

Mr. NAUGHTON. And your figures for Idaho show an average cost for completed ECF audits which is $500 higher than the highest average cost for hospitals.

Mr. MAYNE. Well I would certainly want to look at that figure for Idaho, in ECF's. I would suspect that it could well be a computation error.

Mr. NAUGHTON. Anyhow, it is unusually high, if it is correct?

Mr. MAYNE. Unusually high is hardly the word for it.

Mr. NAUGHTON. And these are for the completed audits, when all the work is done. Would this be through final settlement?

Mr. MAYNE. These audit billings received would represent the actions that had been completed, I would guess. I would refer to Ouloosian here. I would suppose there could be situations where a subsequent bill would come in, but only for a few hours, if the final settlement involvement was not included.

I think the point you want to make here, in looking at these 3 years, is that this is not describing an equal volume of work as you are aware, in each of these periods. There is a cumulative effect. There will be

many situations where, in the second billing year, you are still dealing with the first cycle audits, and this would even be true to some degree in the third billing year.

So it has no relationship to the cycle of audit.

Mr. NAUGHTON. Well, these figures are computed on the basis of the unit cost for a completed audit for a provider, even though the cost might have been incurred and partially paid in an earlier period. The figure reflects audits completed during the fiscal year and represents all costs attributable to that particular completed audit.

Mr. MAYNE. That is right.

Mr. FOUNTAIN. You are not prepared at the present time to give an explanation or to attempt to explain why the Idaho costs were so high?

Mr. MAYNE. No, I could not give you an answer here. I would be glad to get that.

(NOTE.—See material submitted for record on p. 180.)

Mr. FOUNTAIN. Every month you prepare a report showing provider audit activity by each intermediary, don't you?

Mr. MAYNE. Showing provider audit activity by each intermediary, the number of providers, and the status of the audit activity, yes.

Mr. FOUNTAIN. In other words, this report shows the number of audits started by each intermediary and the number which have been completed up to the time of the reports?

Mr. MAYNE. Right.

Mr. FOUNTAIN. And you prepare another report every 3 months which analyzes the administrative costs reported by each intermediary, don't you?

Mr. MAYNE. Yes, sir, we do.

Mr. FOUNTAIN. And that report shows the total audit cost incurred by each intermediary for the period covered by the report?

Mr. MAYNE. That is correct. We keep those two figures separate.

Mr. FOUNTAIN. They are stated separately from other administrative costs?

Mr. MAYNE. Right.

Mr. FOUNTAIN. Is the information on which the provider audit activities report and the cost reports are based, obtained from the intermediaries?

Mr. MAYNE. Yes, sir.

Mr. FOUNTAIN. I wonder if you would briefly identify for us the number and the types of providers serviced by the Washington, D.C. Blue Cross plan and the geographical area in which they are located?

Mr. MAYNE. Yes, sir, I will be happy to do that. The Washington, D.C. Blue Cross Plan services 24 hospitals, 14 extended care facilities, and seven home health agencies.

Mr. FOUNTAIN. And they are all located in the District, or nearby Virginia and Maryland?

Mr. MAYNE. They are located in the District or adjacent to the District in Maryland or Virginia.

Mr. FOUNTAIN. According to your January provider audit activity report, which I understand is the latest one available at this time, how many audits had been started by the District of Columbia Blue Cross plan since the beginning of the medicare program?

Mr. MAYNE. From the beginning of the program through Jan-

uary 31, they had started nine hospital audits, six home health agency audits, and two extended care facility audits.

Mr. NAUGHTON. A total of 17?

Mr. MAYNE. Seventeen. They have 15 field audits in process.

Mr. FOUNTAIN. How many have been completed since the beginning of the program, according to your January report?

Mr. MAYNE. Two field audits have been completed to date.

Mr. FOUNTAIN. I wonder if you have any information indicating why only two have been completed?

Mr. MAYNE. The difficulty has been due to a number of factors. One of the problems they had was in getting an audit subcontract.

They came in to us at the beginning of 1968 with a proposed subcontract between them and an accounting firm. We, however, had required even though it was not a matter of law or regulation under the Government's procurement regulations, that the intermediaries get proposals from more than one firm in order that we could have some indication as to the appropriateness of cost.

When this audit subcontract was submitted, we could not act on it, because other proposals had not been obtained. There was a considerable delay in obtaining other proposals.

Finally, there was an approval of the subcontract. The contract had a very limited period of time to run. Then they made a subsequent subcontract with another accounting firm.

Mr. FOUNTAIN. Through December 31, 1969, our information indicates that the total provider audit costs reported by District of Columbia Blue Cross plan were $170,023. Is that right?

Mr. MAYNE. I would like to refer that to Mr. Jones.

Mr. FOUNTAIN. Mr. Jones?

Mr. JONES. Is that an accumulated figure, for the program to date?

Mr. FOUNTAIN. Right.

Mr. JONES. I don't have that figure summarized. For the first 6 months of the current fiscal year, they reported $40,700.

Mr. FOUNTAIN. Mr. Naughton, where did we get our figure?

Mr. NAUGHTON. The figures for fiscal 1968 and 1969 were taken from the compiled reports of the Social Security Administration, on intermediaries' administrative costs. The figure which Mr. Jones has just cited of $40,000 for the period from July 1 to December 31, 1969, is taken from a cost report submitted by the District of Columbia Blue Cross.

The figures were, approximately, for fiscal 1968, about $3,000, for fiscal 1969 approximately $125,000, and an additional $40,000 roughly in the last 6 months of 1969, calendar 1969.

The total I believe is the figure that you cited, $170,023.

Mr. FOUNTAIN. Anyway, if that is not accurate, you can submit the appropriate information.

Do you have any information as to how much more will be incurred in audit costs in order to complete the 15 audits that were started but not yet completed as of the time of those reports?

Well, on the basis of past performance, it is likely to be rather a substantial amount, isn't it?

Mr. MAYNE. I think we are saying—relate this figure you have used to the audit work that has been done up to now, with this result, and then what can you anticipate for the total cost when audits are completed?

One of the issues that is involved here is the crediting as audit costs of the preparation of statistical data by the Washington, D.C. Blue Cross plan to support their audit activities.

I believe that at one point there was $113,000 that was identified as auditing costs, which was in effect the preparation of detailed statistical information on charges made, so that there would be a basis for determination of payment under the reimbursement formula, relating charges to cost.

So the figure that you have before you is one that reflects a considerable expenditure that is not directly connected with the audit of the intermediary and is not covered under the audit subcontract.

Mr. NAUGHTON. It is shown as audit costs, though, according to their report?

Mr. MAYNE. According to the reports and the allocation they have made of this.

Mr. NAUGHTON. This is what they say it cost to conduct these audits?

Mr. TIERNEY. To prepare to conduct the audit, Mr. Naughton, and there may be some reallocation of those costs between overall administrative expense and audit costs when the intermediary audit is completed.

Mr. NAUGHTON. Well, anyhow, you don't expect to get those 15 unfinished reports completed for free, do you? So it has cost $170,000.23 so far——

Mr. MAYNE. No, not to audit those reports, sir.

Mr. NAUGHTON. Well, audit costs.

Mr. MAYNE. If those are appropriate charges to audit cost.

Mr. NAUGHTON. Well, this is what they are asking for, whether you pay it is another question.

Mr. MAYNE. This is not an issue of request. This is a matter of the allocation.

If every penny is appropriate as determined by the audit of the records, there is still the matter as to whether the allocation of this cost to audit or some other phase of their operation is appropriate. It is an important distinction.

Mr. FOUNTAIN. Do I understand that you reimburse them for becoming qualified to prepare the audit report?

Mr. TIERNEY. Yes, Mr. Chairman, as a part of their total administrative expense, one of the functions they do is prepare this data. Now we have had in audits of other intermediaries the same problem of how you allocate these costs or costs that are incurred. But are they appropriately identified as audit costs or properly identified as statistical compilations under other administrative expenses?

We don't know yet how much of that they will finally be allowed as appropriate audit expense.

Mr. NAUGHTON. If you don't allow it as audit expense, do you expect to allow it as administrative expense?

Mr. TIERNEY. Yes, I assume so.

Mr. NAUGHTON. So you will take it out of one pocket and put it in another?

Mr. TIERNEY. We don't know that they will be allocated to auditing.

Mr. FOUNTAIN. But it will be part of the medicare expense?

Mr. TIERNEY. If they are appropriate expenses.

Mr. Ouloosian. I would like to add a figure. We have been kicking around a figure of more than a hundred thousand expended, and I just did some quick figuring——

Mr. Naughton. It was $170,000.

Mr. Ouloosian. I have been going through some data that a member of your staff and I had reviewed together about a week ago, and in looking at this, I see that the intermediary has reported to us that it has actually paid out to audit firms, or to an audit firm for provider audit activity, a total of $22,500, as contrasted with the $170,000.

I think I would like to bring that into perspective. So the amount of money that has been expended to date, or through January 31, 1970, for provider audit activity for the field work, et cetera, has been $22,500, approximately.

(Mr. Ouloosian subsequently supplied the following additional statement:)

Subsequent to the hearing we contacted District of Columbia Blue Cross to verify expenditures for provider field audit activity since the beginning of the program. District of Columbia Blue Cross reported total expenditures of $30,154.84. A month-by-month verification of 1,822 part II reportings showed that we were missing one month's report. Thus, District of Columbia Blue Cross paid out slightly over $30,000 for the performance of provider field audit work rather than the $22,500 reported in testimony.

Mr. Naughton. Who was that paid to?

Mr. Ouloosian. The accounting firm.

Mr. Naughton. Which one?

Mr. Ouloosian. Lybrand Ross Brothers & Montgomery.

Mr. Naughton. Did any other auditing accounting firms get payments?

Mr. Ouloosian. No.

Mr. Naughton. Are you sure that is an accurate figure?

Mr. Ouloosian. I am as sure as I am that the data is here, and I just totaled it. I can only be sure of what I have before me. I think this is what they reported. I totaled the figures and I did a fast adding and dropped the units and tens digits, and it seems to me to be $22,500. (See statement above.)

Mr. Naughton. How did they spend the other money?

Mr. Ouloosian. I think that was just discussed a moment ago.

Mr. Naughton. Can you give me details? It is still mysterious to me.

Mr. Ouloosian. I don't know. All I am saying is that for the field audit work, they spent $22,500, and not $170,000. I don't know how much of the $170,000 involves other activities we have just talked about; as Mr. Tierney pointed out, after audit, we may reallocate some of these costs to other cost centers if they were in fact incurred, and were proper costs to medicare. However, the data before me shows that $22,500 was paid for field audit work and not $170,000.

Mr. Mayne. I think I used the $113,000 figure; I had figured the cost of preparing detailed statistics on payment relating cost to charges, since that was a figure that was used in one of our contract performance reviews, of which you have been furnished a copy.

Mr. Naughton. Of course the amount paid to a CPA firm for an audit subcontract doesn't necessarily represent all of the auditors that are working on provider audits, because a number of the Blue Cross

plans and some of the commercial intermediaries have their own auditors who are on salary and go out and make these audits, do they not?

Mr. OULOOSIAN. You are correct, but District of Columbia Blue Cross does not have inhouse staff to do the field work, so all field work to date that has been done, has been done under subcontract with that particular audit firm.

Mr. NAUGHTON. So whatever else the $148,000 may have been spent for, it didn't go to auditors?

Mr. OULOOSIAN. Not for field work. There would be expenditures for inhouse staff for some desk review work, supervising and overseeing the work of the audit capability.

So that these types of expenditures may be in that $170,000.

Mr. NAUGHTON. How in the world can an intermediary run up $170,000 to start 17 audits and complete only two of them—this is their total cost—which is an average of slightly over $10,000.

Mr. OULOOSIAN. I thought we had pointed out that after the auditors—DHEW—conduct their audits, we may not have $170,000 in that provider auditing line.

Mr. MAYNE. Mr. Naughton, there are 45 providers we have identified as being serviced by Washington, D.C. Blue Cross. It means then that in the amount that they expended, as we described it a while ago, for the development of the statistical data, that they are accumulating data from their bills on the payments made to these 45 providers for a continuing period of time, breaking this down in detail, so that it may be used in the process of the audit in determining the ratio of cost to charges.

So that it is not a matter of relating a figure to a number of audits that have been started or completed. It is a matter of saying here is the cost of developing and continuing an extensive EDP operation to develop on a current and continuing basis the costs or the charges from bills to us in the audit process.

Mr. FOUNTAIN. If that be true, notwithstanding the present average cost of $10,000 per audit for every audit started, the cost should go down on the additional audits that are completed, shouldn't it?

Mr. TIERNEY. Yes, sir; because that has been incurred for all of the institutions, and therefore isn't repetitive.

Mr. NAUGHTON. Now in terms of the record of audits completed as compared with those started, do you have any other intermediaries that have as low a percentage of field audits completed to those started as that of the District of Columbia Blue Cross?

Mr. MAYNE. Well, we can certainly look through the record and determine precisely.

(The following statement was subsequently provided:)

No other intermediary has as low a percentage of field audits completed as the Washington, D.C. Blue Cross Plan. The next closest intermediary has completed better than twice the percentage of audits as the D.C. Blue Cross plan.

Mr. NAUGHTON. Do you know of any at the moment that are worse?

Mr. MAYNE. I don't know of any that have only completed two.

Mr. NAUGHTON. Are there any more down near that category?

Mr. MAYNE. Not to my knowledge.

Mr. NAUGHTON. Where in the audit cost reports submitted by District of Columbia Blue Cross is there segregated—if at all—the figures for the outside audits? Aren't all those figures lumped together? Can you pick out $22,000 from your report and show me where it is?

I see $170,000 and I can't break it down.

Mr. Ouloosian. Well, a member of your staff and I reviewed the form 1822, schedule 2. That is a form on which the intermediary reports—on a monthly basis in the past, and in the future on a quarterly basis—the amount of money it paid out to audit firms under subcontract to do provider audit work.

We reviewed the 1822's we had for District of Columbia Blue Cross and I just now ran a quick total. The figure that I just cited—$22,500—came from these reports.

Mr. Naughton. Can you tie those figures back into the interim report?

Mr. Ouloosian. No, there is no attempt to tie it in.

Mr. Fountain. Does the report show a breakdown or just a total figure of $170,000?

Mr. Naughton. Well, the totals which make up the $170,000.

Mr. Jones. The interim report only shows a total for the provider auditing line. There is no breakdown between cost incurred directly by the plan and those incurred by outside firms.

Mr. Fountain. But you do get a breakdown eventually?

Mr. Mayne. We get a breakdown from the actual report of the audit activity by the subcontracting firm.

Mr. Naughton. You don't now have, in any kind of available form that you could submit to us do you, a breakdown showing for each of your intermediaries the amount of cost attributable to audit subcontracts and the amount which is composed of in-house expenditures?

I am not asking you to compile it, because it would be a terrific job; I am asking if you have it avaliable?

Mr. Mayne. We have not run, on an intermediary basis, this kind of a tabulation.

Mr. Naughton. So while it may be possible——

Mr. Mayne. We have the information, but it would require the tabulation of some 5,000 of these 1822 forms.

Mr. Naughton. And as of this moment you just have no idea or you don't know with any certainty how much of each intermediary's reported audit costs are incurred by hired personnel and how much under audit subcontracts?

Mr. Mayne. We do not have a precise figure.

Mr. Naughton. It could be compiled eventually?

Mr. Mayne. The issue is not overly significant in that we certainly get into this when the review of the audit of the intermediary's cost is made.

Mr. Naughton. Well, of course the ultimate figure is how much it costs to conduct the audit, is it not?

And this may be composed of expenditures that are incurred by salaried personnel, maybe some computer time, and maybe auditors hired or under subcontract. But you take all of these and include them in the reported audit costs, and divide by the number of audits completed. When the audits are all completed, and the costs are all in, that gives you an average figure which I think you cited as averaging significantly under $3,200.

Mr. Mayne. These are the total costs of field audits conducted by outside audit firms, Mr. Naughton, as reported by the intermediaries, and as will be verified on audit.

Mr. NAUGHTON. How many other intermediaries, to your knowledge, prepare their own P.S. & R. reports, or data similar to P.S. & R. reports?

Mr. MAYNE. There have been a number of the Blue Cross plans that have prepared this statistical data because it was part of their operation when they took over the responsibility for the program.

Mr. NAUGHTON. Did you ask to do it—instruct them to do it?

Mr. MAYNE. No, we did not.

Mr. NAUGHTON. Did you approve in advance their doing it?

Mr. MAYNE. In certain instances, we said, since this was already made a part of it, they could continue it.

Mr. NAUGHTON. In how many instances did you grant such approval.

Mr. MAYNE. I would have to review the record.

(NOTE.—As of the time the hearings were prepared for printing, the requested information had not yet been supplied.)

Mr. NAUGHTON. Did you grant such approval to the District of Columbia Blue Cross,

Mr. MAYNE. I believe not.

Mr. NAUGHTON. Let me ask you this—Do you or do you not prepare in the Social Security Administration in Baltimore a similar report without cost to the intermediaries which is provided to the intermediaries for their auditing purposes?

Mr. MAYNE. Yes, we do.

Mr. NAUGHTON. Why don't they simply use that report and save that $113,000?

Mr. MAYNE. This gets into a long story.

Mr. NAUGHTON. Well, for $113,000 I think we can take a few minutes to hear it.

Mr. MAYNE. The issue gets into the whole problem of the preparation of this report, assembled on a national basis from the data we get from the bills.

This represents, or did represent, to the Social Security Administration, a very substantial undertaking. The problems inherent in it are the problems that are inherent in any volume process.

There are errors made along the line. Providers make errors in submitting the bills, even to the point of getting the wrong provider number on the bill. Errors are made subsequently.

So that when this material is put together in machineable form and then is spilled out on a provider basis, we found at the beginning when we first started this that we had a great number of problems.

On top of this is the real problem of the lag in the process. Strangely enough, providers do not send a bill in the day the individual is discharged. In the past, the average length of time for submitting a bill from the provider to the intermediary has been over 19 days. In many places, it has run over 40 days.

The intermediary must process the bills, it must in turn batch them, get them under our procedures into Baltimore in certain form. This takes perhaps an additional 30 to 40 days.

Then there is the problem of putting this through a punching operation, accumulating this on tape, and from the tapes producing a record.

So the lag is fairly substantial. There will be a certain number of bills that will not be acceptable because of the errors in them. This further interferes with the accumulation of accurate data.

The whole process has then been one of trying to refine the activities at each of the steps to assure that we get an accurate product, even though there will be some differences when we come out with P.S. & R. report.

Now, in the earlier period, there were judgments made that if some of these plans that had the capability and were using it, were going to carry it forward in their audit it would be appropriate to continue that until such point as our system was perfected.

Mr. NAUGHTON. So in effect they were duplicating what you were trying to do? But were they able to do it more expertly and correctly than you were able to do it?

Mr. MAYNE. I have not reviewed their products, so I could not say.

Mr. OULOOSIAN. Mr. Naughton, may I add that we have a number of intermediaries who are on what we call tape-to-tape billing.

Instead of sending us, the Social Security Administration, a hard copy of the billings for our internal processing, they actually do all the keypunching and tape preparation work and just mail us the tape.

I don't know offhand how many intermediaries are on tape-to-tape billing.

Mr. NAUGHTON. Is Blue Cross D.C.?

Mr. OULOOSIAN. I believe, and we can furnish it for the record subsequently, that D.C. Blue Cross is one of the intermediaries on tape-to-tape billing.

Mr. NAUGHTON. Mr. Mayne shook his head.

Mr. MAYNE. I said I don't know.

Mr. NAUGHTON. You don't know and Mr. Ouloosian isn't sure. Does anybody know?

Mr. OULOOSIAN. I believe it is on tape-to-tape billing. If it is, then the preparation of the P.S. & R. would be a byproduct of the tape-to-tape billing activity.

Mr. NAUGHTON. Relatively cheap?

Mr. OULOOSIAN. Yes.

Mr. NAUGHTON. Why would it cost $113,000?

Mr. OULOOSIAN. Well, the $113,000—if that is the figure—may be the money they are spending in connection with the tape-to-tape activity. In other words, doing all the key punching.

Mr. NAUGHTON. Does anybody know how much—maybe it was necessary because you couldn't turn out an accurate enough product—but how much does it cost the Social Security Administration to prepare P.S. & R. reports?

Mr. TIERNEY. I don't know that we could give you a precise figure on that without some study. It is a costly procedure, Mr. Naughton. We have had—a figure in the back of my head—at one time 480 keypunchers alone preparing this report.

It hasn't been a totally satisfactory product, for all of the reasons that Mr. Mayne alluded to plus the fact that you have subsequent credit sent in on bills, subsequent changes in bills.

We have the problem of settling with providers on the basis of a fiscal year. They have bills received in 1 year, and they split the year. It's been a very long hard preparation.

In the earlier stages, we sent this material out, and many intermediaries found that it just didn't match the records of the hospitals and wasn't a useful item.

We think we are getting toward a very much perfected operation at this time. In the meantime, as Mr. Mayne said, we did allow people who have the data on hand on who had it in more usable form than we were able to present it, to go ahead and continue that operation.

Mr. NAUGHTON. But District of Columbia Blue Cross was not one of those?

Mr. TIERNEY. I don't know. Mr. Mayne said he thought not.

Mr. NAUGHTON. Can you provide a list for the record of the intermediaries for whom production of their own P.S. & R. report was approved and your estimate, or figures if you have them, as to the amount that it has cost?

(The following information was subsequently supplied:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., May 4, 1970.

Mr. THOMAS M. TIERNEY,
Director, Bureau of Health Insurance,
Social Security Administration.

DEAR TOM: The following information is in response to your request to secure specific P.S. & R. data on an individual Plan. All Blue Cross plans, pursuant to Administrative Bulletins 34, 34A and 34B have accumulated claim data following the general rules put forth in these bulletins. Examples of some of the payment data recommended for storage would be: date of payment, days or visits, amount paid, total charges, patient payment and type of claim. This data has been used extensively by Blue Cross Plans in the areas of reimbursement and audit for the purpose of sound financial control and to facilitate good accounting practices.

Eighteen of the plans as indicated by the attached exhibit have prepared reports that contain many of the main ingredients of the SSA prepared by P.S. & R. report. More specifically, this would include an itemization of departmental covered service charges, coinsurance days, and net reimbursement amounts per fiscal accounting period.

We appreciate this opportunity to be of service and trust the information will be of some assistance to you.

Very truly yours,

BERNARD R. TRESNOWSKI,
Senior Vice President, Government Programs.

		Dates		Date started tape-to-tape billing	Costs		Annual cost report, SSA–1615
		Development	Operational		Development	Operation (average monthly)	
060	New Haven, Conn	February 1969	October 1969	March 1969	$1,707.67	$34.49	Line 7.
080	Washington, D.C	June 1966	March 1967	January 1970	[1] 12,000.00	2,500.00	Line 5B.
190	Baltimore, Md	December 1968	April 1969	April 1969	[1] 7,800.00	166.66	Line 3A, 7.
200	Boston, Mass	April 1968	Not operational	August 1969	[1] 5,000.00	([2])	Line 7.
220	St. Paul, Minn	June 1967	October 1967	December 1969	[1] 25,000.00	416.66	Line 5B, 7.
230	Jackson, Miss	July 1966	September 1968		[1] 300.00	66.66	Line 7.
250	Great Falls, Mont	September 1968	January 1969		[1] 1,800.00	129.16	Line 5A, 7.
260	Omaha, Nebr	August 1967	January 1968	February 1969	[1] 13,840.00	257.08	Line 7.
270	Concord, N.H	July 1966	July 1967		[1] 25,000.00	83.33	Line 5B, 7.
290	Albuquerque, N. Mex	December 1966	do		[1] 2,000.00	20.83	Line 5B.
303	New York, N.Y	August 1968	January 1969	November 1968	[1] 14,252.00	760.75	Line 7.
310	Chapel Hill-Durham, N.C	March 1968	June 1968	January 1970	3,500.00	166.66	Do.
320	Fargo, N. Dak	July 1967	September 1967	Test	1,950.25	61.97	Do.
332	Cincinnati, Ohio	January 1970	March 1970	November 1969	2,319.37	([2])	([2]).
334	Columbus, Ohio	March 1967	July 1968		1,191.00	145.41	Line 7.
340	Tulsa, Okla	November 1966	November 1966	September 1969	2,200.00	425.00	Do.
350	Portland, Oreg	January 1970	June 1970	Test	1,034.00	([2])	([2]).
392	Memphis, Tenn	November 1969	January 1970	November 1969	2,500.00	([2])	([2]).

[1] Estimate. [2] Not applicable—costs in next fiscal period.

Budget Bureau No. 72-R761

FINAL ADMINISTRATIVE COST PROPOSAL
HOSPITAL INSURANCE BENEFITS PROGRAM

ORGANIZATION *(Name and address)*

PERIOD COVERED

IDENTIFICATION NUMBER

FROM _____ TO _____
(Intermediary's Fiscal Year)

OPERATION OR DEPARTMENT	PERSONAL SERVICES		OTHER COSTS	TOTAL COSTS
	AVERAGE MANPOWER	COSTS		
(a)	(b)	(c)	(d)	(e)
1. Executive		$	$	$
2. Beneficiary (Subscriber) Services				
3. Claims				
A. Claims Processing				
B. Utilization Review				
4. Professional and Hospital Relations				
5. Financial				
A. General				
B. Auditing Provider Records				
6. Statistical				
7. Data Processing				
8. Office Services				
9. Other *(Specify)* _____				
10. _____				
11. _____				
12. _____				
13. _____				
14. _____				
15. TOTAL		$	$	$

16. (a) Number of Bills Processed _____
(b) Unit Cost per Bill (15(e) ÷ 16(a)) $_____
(c) Total Dollar Benefits Paid $_____
(d) Ratio of Administrative Costs to Total Benefits (15(e) ÷ 16(c)) _____

17. Distribution	Previously Reported (Form SSA-1527)	Adjustment (+ or −)	Cost Proposal
January through June 19	$_____	$_____	$_____
July through December 19	$_____	$_____	$_____
TOTAL	$_____	$_____	$_____ *(Line 15(e) above)*

18. Remarks:

FORWARD THE COMPLETED FORM IN TRIPLICATE TO:

Social Security Administration
Bureau of Health Insurance
P.O. Box 1417
Baltimore, Maryland 21203

19. I certify to the best of my belief or knowledge these data are accurate, complete and current as of this date.

SIGNATURE OF CERTIFYING OFFICER

TITLE OF CERTIFYING OFFICER

DATE OF CERTIFICATION

FORM SSA-1615 (R-65)

Mr. NAUGHTON. Now, you have indicated one of the problems was that the providers were late in submitting bills. The intermediary is in no better shape if the bill hasn't come in than you are is he? In other words, a lot of these problems in preparing an accurate report, would be just as much a problem for the intermediaries as for SSA, if they emanate with the provider?

Mr. MAYNE. Yes, this is why I argued in favor of perfecting the P.S. & R. report. The only difference in lag is a difference in transmission time from the intermediary to us.

Mr. NAUGHTON. Was it your purpose in allowing these intermediaries, in effect, to duplicate what you were trying to do, to expedite the audit activity and get it completed more quickly?

Mr. MAYNE. Yes, sir; that was our hope.

Mr. NAUGHTON. It didn't do much to produce prompt auditing from the District of Columbia Blue Cross, did it?

Mr. MAYNE. Well, generating the data would not get the auditors out in the field.

Mr. NAUGHTON. If they were in no rush, why didn't they wait for you to perfect the system and save the $113,000?

Mr. MAYNE. That is a question you would have to ask them.

Mr. NAUGHTON. Haven't you asked them? Do you expect to pay the $113,000?

Mr. TIERNEY. We don't have as yet an HEW audit report.

Mr. NAUGHTON. I should say, have you already paid it? Do you reimburse on the basis of interim reports?

Mr. MAYNE. Yes.

Mr. NAUGHTON. Do you expect to get it back?

Mr. MAYNE. Well, we will get it back if the HEW Audit Agency finds it an improper payment.

Mr. NAUGHTON. Well, it wasn't approved, it duplicated what you were doing, and it apparently didn't do much good based on the audit results.

Mr. MAYNE. Well, you are making an unusual judgment, sir, that it didn't do much good, if you say that the development of statistical data should have also assured that they would have been able to get a subcontract with an accounting firm and carried on an effective audit through the accounting firm. They are two entirely different things.

Mr. FOUNTAIN. I would like to say for the benefit of any representative of the District of Columbia Blue Cross, or any other plan, who may be present, that we are not trying any individual organization, except as the facts may have that indirect result.

We are simply picking those where the costs are high. We are hopeful we will come out with a recommendation to reduce the cost of medicare.

I think everybody realizes it is extremely high and I have already reached a conclusion that this reasonable cost formula is ridiculous. In my opinion, somebody is going to have to find a better formula than that.

Mr. TIERNEY. As you may know, Mr. Chairman, the administration is proposing and of course is discussing with the Ways and Means Committee, and has been with the Senate Finance Committee, a new method of reimbursement. I think the administration agrees with you.

Mr. FOUNTAIN. Dealing specifically with administrative costs, is it true that the District of Columbia Blue Cross Plan has the highest average unit cost per bill processed of any Blue Cross plan in the country?

Mr. MAYNE. I suppose you would need to look at all of the period involved. I would like Mr. Jones to give me a figure for the fiscal year 1969.

Mr. JONES. For the 1969 fiscal year, they had the highest cost of any Blue Cross plan.

Mr. MAYNE. In the first quarter of 1970——

Mr. FOUNTAIN. Excuse me—how much higher?

Mr. JONES. Well, their unit cost was $5.56 for fiscal 1969 and the average for all of the part A intermediaries excluding provider auditing was $3.46.

Mr. TIERNEY. Is that for comparable sizes?

Mr. JONES. $3.46 was average for all part A intermediaries.

Mr. NAUGHTON. For the Blue Cross plans alone, what figure do you have as the average?

Mr. JONES. For the Blue Cross alone, the average is $3.45.

Mr. NAUGHTON. Does that include Blue Cross National Association?

Mr. JONES. Yes.

Mr. NAUGHTON. If you include just the plans, it comes to $3.43?

Mr. JONES. $3.25.

Mr. FOUNTAIN. I have a figure indicating that for the last 6 months of 1969, District of Columbia Blue Cross reported costs per bill excluding audit averaging $6.84. Is that right?

Mr. TIERNEY. The last 6 months of calendar 1969?

Mr. JONES. I have the data for the first half of the current fiscal year—$6.56.

Mr. FOUNTAIN. $6.56?

Mr. TIERNEY. That would be the last 6 months of calendar year 1969.

Mr. NAUGHTON. Is that a revised report? Didn't they submit $6.84?

Mr. JONES. I understand they have prepared a revised report, but we have not received it.

Mr. NAUGHTON. What is the latest?

Mr. JONES. $6.56.

Mr. NAUGHTON. What is the date on that?

Mr. FOUNTAIN. Do you have July-September 1969 figure?

Mr. JONES. That is $6.56.

Mr. MAYNE. Excuse me, sir.——

Mr. FOUNTAIN. I have a figure of $5.62 for July-December 1969.

Mr. MAYNE. $5.62 is correct for the first fiscal quarter, July-September.

Mr. FOUNTAIN. And for July through December, $6.84?

Mr. MAYNE. The initial report received for July-December 1969 reflected a unit cost of $6.56.

(The amended report referred to above reflected $5.68.)

Mr. FOUNTAIN. How does that compare with the average cost of the bills processed for all Blue Cross plans—I believe you already told us that.

How does the average production per man-year, that is, the average number of bills processed per employee, for the District of Columbia Blue Cross compare with the national average?

Mr. MAYNE. They have a low man-year production. Looking at the first fiscal quarter of 1970, their production per man-year was 1657. This compares to a figure of 2,786 for their group.

I think it is important to treat these in a group rather than the total, since the smaller plans do have—as far as our work is concerned—different kinds of problems from the very large ones.

The figure for the Blue Cross system is 2,975, and for the Nation is 2,773.

Mr. FOUNTAIN. When you say Nation, you mean all Blue Cross plans?

Mr. MAYNE. Blue Cross and commercials.

Mr. FOUNTAIN. When did you first become aware of the fact that the District of Columbia Blue Cross administrative costs were extremely high as compared to those for other Blue Cross plans?

Mr. MAYNE. Well, I suppose we could go back into the early part of 1968. Certainly indications had been present before, but in bringing the issues into focus, we started in May of 1968 with a meeting with them to determine the problems, see what could be done about the high administrative costs, and the low productivity.

And this was followed up by a continuing dialog, both with the plan and with Blue Cross Association. So that we have a record that would indicate in July of 1968 we corresponded with the Blue Cross Association on this issue, that we had in October of that year a visit to the Blue Cross plan, and that from that point on we have had a series of exchanges, attempting to get at the problem and reduce the cost.

Mr. FOUNTAIN. Do you think you have been able to get any fruitful results?

Mr. MAYNE. Well, certainly the record would say that the costs have not decreased. I think the basic problems are the ones that have been identified—the productivity, and the number of people that are used in the operation. I believe that some work that is being done by both the plan and Blue Cross Association in changing the system, in reducing the manual operations, and getting more into a computerized operation, which should indeed be productive.

All these things have been developing over this period of time.

Mr. TIERNEY. I think there are two very basic elements to this thing, Mr. Fountain. One is the average manpower they use. Because of their manual operation they are roughly double the average manpower employed in plans of comparable size and comparable operations.

The other obvious factor involved is that their salary costs are very high, so when you have double the manpower at a very high salary level, this is the reason for their high unit cost.

They are, as Mr. Mayne says, now engaged in attempting to convert to the so-called Blue Cross Association Model A data processing system, and over the long pull that would, I believe, make a very marked difference in their operating expenses.

Their average salary—with the exception of one other plan—is the highest for plans of comparable size—$7,333 for the July–Sept. 1969 period.

Mr. FOUNTAIN. Have any other efforts been made, other than the ones you have already explained, in attempting to understand just why the administrative costs of the District of Columbia Blue Cross are so high, as compared with other Blue Cross plans?

Do you ever pick up the telephone and say, what in the devil is going on down there? Your costs are mighty high. How about checking them?

Mr. TIERNEY. We do a lot of that, Mr. Fountain. It doesn't show on the record, but we are great telephoners.

Mr. MAYNE. That has been done with the plan and with the Blue Cross Association. As I indicated, we have quite a record of correspondence on this. So it is not that we have been unaware of or have not turned to the channels that were appropriate to us.

Mr. FOUNTAIN. Have you at all times received full cooperation from officials of the District of Columbia Blue Cross plan?

Mr. MAYNE. There have been one or two instances when we did not receive full cooperation. We made an issue of this with the prime contractor and the matter was straightened out.

Mr. BROWN. Who is the prime contractor?

Mr. MAYNE. Blue Cross Association.

Mr. BROWN. In Chicago?

Mr. MAYNE. Yes.

Mr. FOUNTAIN. Give us the details on that.

Mr. MAYNE. We had arranged for a meeting with the plan to discuss the problems of high administrative costs. The arrangements we felt were firmly made, and the object of our visit was clearly determined.

When the time came to make the visit, some plan personnel felt that the purpose of the visit was not completely identified in the communication that they had received, so they refused to cooperate.

Mr. FOUNTAIN. Refused to allow the personnel to review the operations?

Mr. MAYNE. Or with such limitations that there was no point in going ahead with the visit. That was when we first picked up the phone and then sent a letter and said, under the terms of the contract, we expected that this visit would be made or that we would expect that we would have to take action to terminate the agreement.

Mr. NAUGHTON. That refusal was considered by the personnel involved to be a breach of the contract, was it not? In other words, the SSA personnel went down to review the operation—they thought they were going to—and when permission was refused for them to try to find out why it was costing so much, they considered that a violation of the contract sufficient to justify termination?

Mr. MAYNE. A continued refusal would be justification for termination of the contract. Under the provisions of the contract the Secretary has the right to inspect.

Mr. NAUGHTON. What recommendations did that team make as a result of their abortive visit?

Mr. MAYNE. What recommendations did they make to whom?

Mr. NAUGHTON. To the Social Security Administration, for action to follow up and try to get these costs in line, when they came back to the office after having been refused permission to review the high cost operations of Blue Cross.

Mr. FOUNTAIN. What was their report?

Mr. MAYNE. The report was that they couldn't get in and naturally they would feel like anyone in that circumstance, that some steps should be taken to arrange for them to get in and that the terms of the contract be carried out.

Mr. NAUGHTON. Didn't they make three specific recommendations?

Mr. MAYNE. The team? On coming back?

Mr. NAUGHTON. Yes. Who in your shop is familiar with what is going on at District of Columbia Blue Cross? Do you have anybody who has been following the situations and knows what has been going on down there?

Mr. MAYNE. Well of course we have, sir. We have a contract administrator.

Mr. NAUGHTON. Is he here?

Mr. MAYNE. He is not here.

Mr. NAUGHTON. Is there somebody here who recalls these three recommendations?

Mr. MAYNE. We will be glad to get those for the record.

Mr. NAUGHTON. Well, we told you before the hearing today that one of the specific purposes was to get all the information we could as to why the cost of District of Columbia Blue Cross is so high, and what has been done in trying to get them down.

Mr. TIERNEY. Do you have a copy of the recommendations, Mr. Naughton?

Mr. FOUNTAIN. Let's put it in the record and then they can supplement it or refute it.

Mr. NAUGHTON. I have notes indicating the sense of the recommendations.

Mr. TIERNEY. We will be glad to give you a copy of whatever recommendations were made.

Mr. NAUGHTON. This is a report of September 10, 1968, on the meeting with District of Columbia Blue Cross at which SSA personnel were refused permission to review the medicare operation. And the recommendations in this report are as follows:

Recommendation No. 1—the action taken by Mr. Gamble—and Mr. Gamble is or was the assistant director of Blue Cross who actually refused permission—

The action taken by Mr. Gamble should be considered as a breach of contract justifying termination of the carrier agreement with Medical Services of the District of Columbia, and the subcontract between BCA and GHI.

Recommendation No. 2. Since budget approval has not been issued for GHI beyond the first quarter fiscal year 1969, consideration should be given to requiring the Plan to submit monthly invoices with proper narrative. These invoices, upon approval by SSA, would be paid by SSA, not BCA. If any invoice is received with incomplete narrative or improper entries, the invoice should be returned to the Plan and no payment should be authorized until all discrepancies have been remedied. When action to reduce costs has been taken by the Plan and is satisfactory to SSA, the normal budgeting process could be resumed. Consideration should also be given to changing Medical Services of the District of Columbia to this method of reimbursement.

Recommendation No. 3. A special team be organized by SSA to do a complete study of the operations of both GHI and MSDC, to determine why the costs are as high as reported, and to recommend action to be taken by GHI and MSDC to correct the situation. Return all reports to BCA or GHI and MSDC if they are not mathematically correct, accompanied by properly detailed narratives, or are in any other way unacceptable. Require submission of interim expenditure reports on a monthly basis, rather than the quarterly basis.

Those are the recommendations. What action was taken?

Mr. FOUNTAIN. Who made those recommendations?

Mr. NAUGHTON. These are made by the team who were down at the District of Columbia Blue Cross from the Social Security Administration.

Mr. FOUNTAIN. And to whom?

Mr. NAUGHTON. I assume the report went to Mr. Mayne through channels.

The participants from SSA were Tom Bair, Bureau of Health Insurance, regional office, which I guess is in Charlottesville. Len Nicoski, Baltimore, Contract Administration Branch, Division of Intermediary Operations, and Don Posen, Social Security Baltimore, Contract Financial Management Branch, Division of Intermediary Operations.

Mr. FOUNTAIN. These recommendations were made to you, Mr. Mayne?

Mr. MAYNE. They were made to me. Those are my employees with the exception of Tom Bair.

Mr. FOUNTAIN. What action did you take?

Mr. MAYNE. The first step was to go to the prime contractor, as I described awhile ago, and I first called and said, we have this situation, which is extremely serious. This has to be straightened out or we will have to take the steps required under the contract for termination.

The response from Blue Cross Association was, of course, we don't condone this at all, we will get this straightened out right away. So a letter was sent——

Mr. FOUNTAIN. What was the date of that call, approximately?

Mr. MAYNE. I don't have the date of the call, but probably the next day after the team got back.

Mr. FOUNTAIN. What was the date of the report of the team?

Mr. MAYNE. September 10, I think.

Mr. NAUGHTON. September 10, 1968.

Mr. MAYNE. So we did arrange for a clear understanding as to what was to be done, and we then sent a team in and that team developed a report and made an analysis.

Now as to the other parts of the recommendation, it seemed appropriate to wait on what a visit would produce. As far as the second recommendation made, this certainly was one that would be made by an individual who felt there ought to be some way to get control of it. But the recommendation would have exceeded the legal authority that we have under the terms of our contract. We could not have carried out the kind of approach that was proposed.

Certainly it is appropriate that the team make suggestions, but as with any suggestion or recommendation made by people in an organization, there have to be judgments up the line as to its appropriateness.

Mr. NAUGHTON. You indicated, Mr. Mayne, that you did send in a special team?

Mr. MAYNE. Yes, we sent in a team.

Mr. NAUGHTON. Who were the members of that special team?

Mr. MAYNE. I don't have that here, but I will furnish it.

(Members of the team were Don Posen, David Walker, Len Nicoski and Tom Bair.)

Mr. NAUGHTON. Was this a special team or was it the normal contract performance review that you make for all intermediaries?

Mr. JONES. We had both a contract performance review and also a special team went in, and the special team was looking primarily at the cost.

Mr. NAUGHTON. Did they file a report in addition to the contract performance review report?

Mr. JONES. They did file a report, sir.

Mr. FOUNTAIN. When was that?

Mr. JONES. They filed a report in February 1969.

Mr. FOUNTAIN. What is the substance of that report?

Mr. JONES. The plan officials were cooperative in terms of making procedures and cost data available. However, the team was still not satisfied that the cost as shown by District of Columbia Blue Cross was justifiable.

Mr. FOUNTAIN. Did they make any additional recommendations?

Mr. JONES. They did recommend that there was a need for basic and in-depth cost analysis on the part of the plan.

Mr. FOUNTAIN. What was the date of that?

Mr. JONES. This report was filed in February 1969.

Mr. NAUGHTON. At that point, I think it should be pointed out that we have been talking in terms of a $6.50 unit cost for the last 6 months of 1969, which I am sure is by far the highest for any Blue Cross plan. And perhaps double the average for all Blue Cross plans or close to it.

Now, if—as has been earlier suggested—some of the $170,000 in audit costs reported are actually administrative costs, that is going to raise the unit cost even higher, is it not?

In other words, if you transfer some costs from the audit costs in order to reduce the astronomical audit cost figure that you have, it is going to further increase an already astronomical administrative cost figure?

Mr. JONES. We estimated that approximately $53,000 of their cost for the last fiscal year was incurred in connection with assembling data comparable to that included in the P.S. & R. reports.

Mr. NAUGHTON. Which duplicated something you were doing in Baltimore?

Mr. JONES. In terms of a unit cost, that would add 81 cents to the unit cost in fiscal 1969.

Mr. NAUGHTON. At the time of the first review, in September 1968, what was the level of the unit costs?

Mr. JONES. In fiscal year 1968, their unit cost was $5.92.

Mr. NAUGHTON. And after all this concentrated effort that has been described by the Blue Cross Association and by Social Security Administration, it has increased substantially, has it not? In other words, you have not succeeded in accomplishing a reduction?

Mr. MAYNE. I wonder, Mr. Jones, would you give the figures for all intermediaries for 1968 and 1969, and the first half of 1970? I think we had better bring this into perspective, if you have the unit cost figures.

The point I am trying to make, Mr. Chairman, is that there have been increases in cost in the last year for practically all of the intermediaries because of the requirements that we have placed upon them in the area of utilization review and utilization control. So that you are not comparing exactly the same thing in two different years.

Mr. JONES. For fiscal 1968, Washington, D.C., $5.92. The total for the Blue Cross plans, excluding BCA, was $2.79. The total, including BCA, was $2.93. And the total for all part A intermediaries was $2.98.

For 1969, fiscal 1969, Washington, D.C. was $5.56. Total for all Blue Cross plans, excluding BCA, was $3.25. The total including BCA, was $3.45. And the total for all part A intermediaries was $3.46.

Mr. NAUGHTON. Are you satisfied that you really know the cause of these high costs down there?

Mr. TIERNEY. I think the figures and all of the data we have pre-

sented to you and to the chairman, Mr. Naughton, indicate the very basic problems. If you have double the manpower of comparably sized plans with which you are comparing administrative costs, and you are paying the highest average salary of any, this, almost of itself——

Mr. NAUGHTON. Is it true that the president of the District of Columbia Blue Cross gets $65,000 a year?

Mr. TIERNEY. I haven't any idea.

Mr. MAYNE. I don't know.

Mr. NAUGHTON. Well, would your audits show the salaries paid?

Mr. TIERNEY. That would be determined by the HEW Audit Agency, because all overall expenses are allocated between medicare and non-medicare and the Audit Agency would determine the appropriateness of the salary and the amount allocated.

Mr. NAUGHTON. It has been stated that high salary costs is one of the reasons for high costs. I am trying to find out what the executive salaries are and how much is charged to medicare.

Does anybody at Social Security Administration know whether or not the president of Washington, D.C. Blue Cross gets $65,000?

Mr. TIERNEY. No, we don't have an audit of their operation as yet. It's been completed and submitted to them for comment. We haven't received the report.

Mr. NAUGHTON. So you don't know whether or not he does, and if he does, how much of it may be charged to medicare.

Mr. TIERNEY. If there is too much in there, it will be taken out, so these figures will thereby be reduced.

Mr. NAUGHTON. What is the average level at which they start clerks who do the processing of bills?

Mr. TIERNEY. I don't have that information.

Mr. NAUGHTON. It has been stated that high turnover was one of the problems. It seems to me that to ascertain what the problem is, you have to see what the salary levels are, who is getting it, and how well they are performing.

Mr. TIERNEY. They have a very high rate of turnover. In some periods it has exceeded a hundred percent. I don't know whether this is common to the Washington scene. You have a large clerical operation, a largely female operation. I am sure the turnover is a problem everyplace in this area. I don't know whether we have the starting salary figures.

Mr. NAUGHTON. Could you find out and provide it for the record, what the starting salary is for a clerk down there, and what the going rate is for the president also?

Mr. TIERNEY. Certainly. I should say, what they decide to pay the president is their own business. How much is allocated to medicare is ours.

Mr. FOUNTAIN. You have to know in order to determine how much would be allocated; don't you?

Mr. NAUGHTON. Let me say it is the Government's business how much of the salary would be charged to it, and as a subscriber, I have a little personal curiosity.

(The following information was subsequently provided:)

The starting salaries for a clerk at Washington, D.C., Blue Cross vary, depending upon responsibilities assigned to various grades of clerk.

Starting salaries for various classifications of clerks of District of Columbia Blue Cross are:

Grade:	*Starting annual salary*
2	$4,476
3	4,812
4	5,148
5	5,484
6	5,832

The annual salary of the president of Washington, D.C., Blue Cross is $45,688, plus an estimated $12,600 of fringe benefits consisting of the plan's share of social security contribution, bonus, life insurance, retirement, and the use of an automobile.

Mr. FOUNTAIN. Does the Blue Cross Association have the responsibility under their contract for taking action to achieve a satisfactory level of performance by the local groups?

Mr. TIERNEY. Yes, sir; that is their prime responsibility. Our prime contract is with Blue Cross Association, and among the obligations that they assume under that contract is to supervise the quality of performance of the subcontracting plans.

They then subcontract out. And the plans of course understand that obligation. I think you have in your files copies of samples of both the contract and subcontract, with the various functions which have been assigned to them, and it's a BCA obligation to see to it that they perform those functions properly.

Mr. FOUNTAIN. Mr. Mayne, have you had any contact with the Blue Cross National Association in connection with the District of Columbia operation?

Mr. MAYNE. Yes, sir.

Mr. FOUNTAIN. What action did you get from them?

Mr. MAYNE. They have sent people in there. They have had an analysis of their operation with the proposal that they find a way to solve their clerical problems by much higher computerization. They have definitely been involved heavily with the plan.

Mr. FOUNTAIN. They have been concerned with the high administration costs also?

Mr. MAYNE. Yes.

Mr. FOUNTAIN. Before yielding to Mr. Brown, and any questions he might have, I would like to ask what further action, if any, you do intend to take with respect to the situation in District of Columbia Blue Cross?

Mr. TIERNEY. Mr. Fountain, as I told you, in the course of the last year we had issued appropriate notice to all intermediaries of an intention not to renew existing contracts. The contracts come up for renewal on July 1. We have begun a series of negotiations with the Blue Cross Association with regard to their basic contract, and of course the subcontracting plans.

We are just as deeply concerned about this situation, sir, as you are. And we will be trying to reach a judgment as to whether or not there is hope to salvage the operation, and the money that has been spent.

One of the great difficulties, if I may, sir, is this thing, of saying, "Well why don't you terminate a carrier or an intermediary——"

Mr. FOUNTAIN. That was the next question I was going to ask. Suppose you terminated the contract with District of Columbia Blue Cross—what would be the result?

Mr. TIERNEY. We would have to find a new intermediary and the new intermediary would have to establish new relationships with the hospitals, they would have to establish their own process, they would have to hire their own personnel and find their own space, and hopefully, because of a past record of better performance elsewhere, you come out with a better performance. But it's an extremely painful transition.

Our hope to date has been that we could improve the performance of this intermediary and bring down its cost and get it on an acceptable level. If we become convinced we can't, we will make the change, but when we make the change, things are going to be pretty rough for awhile. We have had the experience of changing carriers in a couple of areas, and it finally works out well, but you go through some tremendous traumatic experiences in the process. And you never know, of course, whether, just because somebody has performed well in one part of the country, they are not going to face serious problems in another.

This is one of the limitations that concerns us, frankly. This is our ultimate weapon, to terminate a contract, and it is a kind of overkill in many ways.

Mr. FOUNTAIN. It may not be the best weapon. Mr. Brown?

Mr. BROWN. What are the other choices in District of Columbia?

Mr. TIERNEY. Well, another choice in District of Columbia, as far as the Blue Cross side is concerned, would be for BCA to bring their own personnel in and attempt to operate on a subcontracting basis.

The other thing would be to turn to commercial companies who have been acting as intermediaries—Mutual of Omaha, for example, represents five hospitals and some 15 extended care facilities in the area. So they have more experience in the area than any other commercial carrier at this time, but whether or not they would be the one, the more logical selection, I don't know, Mr. Brown.

Mr. BROWN. Your basic contract with reference to District of Columbia Blue Cross then is written with Blue Cross in Chicago, is that what you are suggesting?

Mr. TIERNEY. That is true of all plans. We made a prime contract with BCA in Chicago. They in turn have subcontracted to the operating plans. That is the only situation in which that occurs, because in the case of the other intermediaries, obviously you are just dealing with one entity. Here we are dealing with literally 74 separate entities; rather than having contracts with each one of them, we make a prime contract with their national organization.

Mr. BROWN. Have you had any indication of anyone else in the District of Columbia area, in the District of Columbia, who would be interested in being the intermediary in the District of Columbia?

Mr. TIERNEY. We have talked, frankly, Mr. Brown, with other carriers and intermediaries both, about the part A and part B performance. We have been talking here about the part A performance this morning. We have had similar problems in District of Columbia with the Blue Shield organization.

And frankly, at this time we are trying to reach a final judgment on whether or not we will make a change there. So we have of course in that process talked to other carriers and intermediaries.

Some have said "No," they are not equipped to take on further responsibility. But others have indicated an interest in doing so.

It's a little difficult to replace Blue Cross with a commercial because commercial availability is limited on the intermediary side—first of all you have the nominating procedure of intermediaries. The hospitals have the right to nominate an intermediary and unless the Secretary finds that this is not in keeping with effective and efficient administration, he is to accept those nominations.

Now we would have to go through that whole procedure in terminating the Blue Cross plan in the District of Columbia, go to the hospitals and home health agencies and extended care facilities, and say, whom do you nominate, and find out if that organization was capable of taking it on, and go through that procedure.

Mr. BROWN. Who has the leverage in this connection? Is there a risk that if you went into an area and asked the hospitals to nominate somebody for intermediary, and they nominated someone that was not acceptable to the Social Security Administration, the hospital might drop out of the operation, and not accept patients under the medicare system?

Mr. TIERNEY. Conceivably that could happen, but it would be farfetched.

Mr. BROWN. So really it's the other way around, that while they nominate someone, SSA can literally go in and say you take so and so as your intermediary or else.

Mr. TIERNEY. That is an interesting legal question at the moment, Mr. Brown. We certainly have the right to say "no," we won't accept that nomination, make another one. And keep making them do that until they come up with the right one. But these doesn't seem to be anything in the law that says the Secretary may impose them upon an intermediary.

They have the right to deal directly with the Social Security Administration if they so choose.

We do have a technical amendment in the present proposed legislation that would allow the Secretary to appoint an intermediary just as he appoints carriers, and remove this nomination procedure.

Mr. BROWN. What is the distinction between an intermediary and carrier?

Mr. TIERNEY. On the part B side, the same fiscal agents for some strange reason are called carriers. On the part A side, they are called intermediaries.

Mr. BROWN. I am sure I understand that, but I will have to think about it.

Mr. TIERNEY. I am not sure I understand it, but it was written into the law.

Mr. FOUNTAIN. It must have been lawyers who wrote it. Being one, I know how different it sometimes is.

Mr. TIERNEY. At that time frankly, I think it had some significance. People were talking of carriers as being people that really underwrote programs, a la the Federal employee health program, and they made quite a fetish about wanting to be known as carriers.

Mr. BROWN. If I may, it seems that the choice that you have is finding a new intermediary/carrier, or winding up eventually with the Social Security Administration taking on this responsibility themselves, isn't that about it?

Is that what we are getting to in this discussion?

Mr. TIERNEY. If we make a judgment to cancel the present arrangement, we obviously have to find a new intermediary/carrier, or they will deal directly with us. But I would hope that wouldn't represent a trend across the country, Mr. Brown. But those are the only alternatives.

Mr. BROWN. Well, let me ask a background question. How long has there been a wide variety of choice in this intermediary activity?

It seems to me that we have a business here, or an adjunct of private enterprise which is relatively new. Is that a fair statement or not?

Mr. TIERNEY. Yes, there is no question. You mean this role?

Mr. BROWN. The role of doing the checking, record keeping, the billing procedures and so forth of hospitals. How long has there been such a thing as an intermediary or carrier in the whole field of insurance coverage hospitalization expenses?

Mr. TIERNEY. Well, to the extent that they are performing the functions under medicare, I would have to say 4 years, since its inception.

Before medicare, commercial insurance companies of course approached health insurance on the basis of indemnity payments largely. They would pay so many dollars when you were in the hospital, or so many dollars toward X-rays and drugs and so forth.

The Blue Cross plans of the country had had a long tradition of cost reimbursement And they therefore had more experience in the concepts of receiving cost reports and going over them and making cost settlements.

Mr. BROWN. Separate that out in terms of time. How long has Blue Cross been doing a cost reimbursement business?

Mr. TIERNEY. I think ever since its inception, which was in the early or midthirities. But in the first place, Blue Cross didn't really blossom into much of an entity until the automobile labor-management negotiations in 1948.

Mr. BROWN. So a total history of 25 or 30 years.

Mr. TIERNEY. Even then, I think I should point out to you that all of the Blue Cross plans didn't pay on a cost basis. Many paid on a charge basis. So that with that correction, you are right. From 1948 on, this type of hospital payments was being made on a large scale.

Mr. BROWN. All right, now, what about other companies? How long have other companies besides Blue Cross-Blue Shield been in a total cost payment basis or method?

Mr. TIERNEY. With the exception of some group health associations, none of the commercial companies had ever been in a cost-reimbursement program. They just didn't reimburse that way.

Mr. BROWN. Until medicare?

Mr. TIERNEY. Yes, sir.

Mr. BROWN. So we are talking about a 4-year history here of this whole field, except for the Blue Cross-Blue Shield operations?

Mr. TIERNEY. Yes, sir.

Mr. BROWN. Do you have the information to compare the operation of the District of Columbia Blue Cross operation with reference to

medicare and its auditing of hospital costs that are not medicare-related hospital costs?

Mr. TIERNEY. For its own purposes?

Mr. BROWN. For its own purposes.

Mr. TIERNEY. We have that information from reports they issue and we issue. I don't know that I have it here, sir.

Mr. BROWN. How do they compare? Are they expensive or above average with reference to medicare auditing, and average or below average with reference to auditing of other hospitalization costs, or are they also above average with reference to other hospitalization costs?

Mr. TIERNEY. I don't think they do the same type of auditing in their own business as in ours. Theirs is a much simplified approach. In the overall, if you wanted to look at it from a point of view of ratio of administrative expense to benefit payments, they do the job for us for 1.37 percent of the benefit payments. That is the ratio between their administrative expense and the benefit payments.

I would have to get you the precise figure on their own business, but I would assume it would be in the neighborhood of 5 percent, which is about the District of Columbia average unless it substantially exceeds the average.

But, of course, in that figure, Mr. Brown, you have sales and advertising and promotion and all kinds of things that we don't recognize as costs, because they are not necessary costs for our program. But I would also assume, without knowing, and I will get you the figures from their own reports, that if they are high cost because of this manual operation and their levels of salaries, they would be high cost in their own business as compared to other plans.

Mr. BROWN. Unless they were loading——

Mr. TIERNEY. Yes, sir.

Mr. BROWN (continuing). The cost into the medicare/medicaid program, which is the issue, of course, I am trying to get an answer to.

In other words, if the District of Columbia operation of Blue Cross is simply an inefficient operation, not only with reference to SSA programs but also with reference to its own operation, that is one thing, and perhaps justifies a change if you can find anybody who is going to be more efficient, although I have learned from painful experience that there are a lot of things in the District of Columbia, including the Federal Government, that aren't terribly efficient.

But it is something else if they are loading the costs into SSA, and maintaining a relatively lean and efficient operation with reference to their own costs.

Mr. TIERNEY. If they are making an effort to do that, it will certainly be picked up by audit and disallowed.

I do have a figure for calendar year 1967 from the Blue Cross Association. Their operating expense as a percent of earned subscription income, was 6 percent as against a Blue Cross average of 5.4 percent. So they are high. But not proportionately to the figures we are talking about.

Mr. BROWN. But we are not talking about the same things, are we?

Mr. TIERNEY. No.

(The following statement was subsequently supplied for the record:)

During the hearing we only had readily available calendar 1967 data on District of Columbia Blue Cross' operating expenses as a percentage of earned subscription income. Financial data issued by BCA in the publication "1969 Blue Cross and Blue Shield Fact Book" shows District of Columbia Blue Cross calendar 1968 operating data (latest published) to be 4.9 percent as against an average percentage for all U.S. Blue Cross Plans of 5.7 percent.

We believe that Mr. Tierney's testimony, with the addition of the above insert, fulfills Mr. Tierney's commitment to Congressman Brown. We have no other data regarding the operating expenses of Blue Cross plans in connection with their own private business.

Mr. NAUGHTON. When you make a comparison on the basis of dollars spent, doesn't the District of Columbia operation have a built-in advantage in that the average hospital bill in the District of Columbia under medicare is substantially higher than the average bill elsewhere in the country?

Mr. TIERNEY. That is right.

Mr. NAUGHTON. Like $400 or $410, to something like $325?

Mr. BROWN. Which would indicate people in the District of Columbia area are either a lot sicker or the hospitals are a lot less efficient?

Mr. NAUGHTON. It doesn't cost any more to handle a bill when the cost is $75 a day than $50 a day, but it makes the cost a smaller percentage.

Mr. TIERNEY. I agree. The ratio depends on the level of both operating expenses and hospital expenses and in Washington, D.C. hospital expenses are very high.

Mr. BROWN. If I may just go ahead and pursue this point for a bit. Given the fact that this is a recently developed area of activity, and given some of the other things that have come out of this hearing and other hearings in the medicare program around Capitol Hill over the last couple of months, it seems to me that either we have to assume that Uncle Sam is going to undertake this kind of auditing and licensing and federalization of approval of hospitals, or we are going to have to find a method to provide for a continual check on the efficiency of the operation of those who do have the responsibility of auditing the intermediaries and carriers, and those who have a responsibility for the safety and efficiency of the operation of hospital care, and so forth.

Now, have you any comment as to whether there is competition in this field that is practical? You suggested a moment ago that the largest stick you could use, or the most effective stick you could use would be to threaten—in the case of Blue Cross, and a national contract would complicate that fact—to lift the contract with them and turn it over to someone else.

How much of a threat is that? Are there other entities knocking at your door or beating a path to your door to take over this responsibility?

Mr. TIERNEY. They are not knocking at the door. I think there are very fine companies which would be glad to assume this responsibility. I think you are putting your finger on something that consideration is being given to by both the Ways and Means Committee and the Senate Finance Committee.

These contracting agencies, the carriers and intermediaries, under the law are to operate on a no-profit, no-loss basis.

Mr. BROWN. We discussed that earlier, and it seems to me that if part of their responsibility is to see that the hospitals in the area operate as efficiently as possible, I am not sure that no-profit, no-loss basis makes sense.

If you can get them to beat down hospital costs in some way, it might be appropriate to make a profit in the process in the interest of holding down the total cost of the program. I understand that is the way it is to operate, so let's go on from there.

Mr. TIERNEY. Is there really competition? Other than professional pride, and not wanting to be pointed out as one of the guys in the black hat; no, sir, there isn't really effective competition, because it isn't a case of putting it out to bid; or rewarding whoever does the most excellent job or penalizing; whoever does the poorest job. You are always going to have a range.

Mr. Brown. What would be the advantage, for instance, to Mutual of Omaha or Aetna in taking over the operation of the auditing and other intermediary/carrier responsibilities in the District of Columbia? Is there any?

Mr. TIERNEY. First of all, they would get a lot of free advertising out of the initial announcement, I suppose. But other than that, to the extent that it enhances their position in the health field; to the extent that perhaps by taking on another operation—Aetna operates, for example, as a carrier now in five States; if they were to take on another operation in the District of Columbia, it might, for example, give them a basis for increasing their computer capacity that would be more effective and efficient, not only for medicare, but also for their own private business.

But it gets difficult, Mr. Brown. I think the original role—many of these people thought, gee, there is going to be a wonderful thing, a Government stamp of approval that we are going to act as an agent of the Government in administering a health program.

As the program has matured and their role has become one not of being the bountiful supplier of funds, but rather the policeman in the act, the one going around taking a long, hard look at utilization, costs, turning down cases. Some of the companies are beginning to wonder, "Is this enhancing our public image, or not?"

Mr. BROWN. There is the possibility they would spread added costs of the company over this part of their operation; isn't that true? In other words, talking about the president's salary in Blue Cross, District of Columbia, they would save a little bit of their overhead costs that their other customers would not have to pay?

Mr. TIERNEY. To the extent you can allocate those costs, I agree with you.

Mr. BROWN. If you were big in this field, in terms of what you were doing for the Social Security Administration, you would have less administrative costs that would have to be borne by your private subscribers and you might enhance your competitive position, might you not?

Mr. TIERNEY. Yes; to the extent that you have fixed overhead costs, some of which you can appropriately allocate to medicare.

Mr. BROWN. Really, the only dollars-and-cents advantage that I can see is the distribution of fixed overhead costs, because if you have variable costs——

Mr. TIERNEY. You just get those back.

Mr. Brown. It's a tradeoff. No advantage.

Mr. Tierney. Right.

Mr. Brown. So the opportunity to share fixed costs is about the only thing.

The loss of promotional advantage becomes more significant the more significant the role of the intermediary carrier is in enforcement, is that correct? Is that what you just said a minute ago?

Mr. Tierney. Well, yes, I think to the extent that a company might think, "We get a large number of providers to nominate us, we serve them well, it enhances our prestige in the community, this is a fine thing."

I am not suggesting that any of them have told us to date they are going to quit. But many of them, as you know from reading the congressional committee reports, have taken some pretty big lumps, and many of them now are making not friends among hospitals or extended care facilities, but bitter enemies because of denial of cases and costs.

From a purely promotional point of view, therefore, I think they may be questioning, "Is this helping our public relations or is it hurting it?" I am putting these thoughts into their minds, but I am trying to be responsive to your question.

I don't think there is any longer any great promotional value in a company being designated as an intermediary or carrier under medicare.

Mr. Brown. Is there an opportunity here for some private entrepreneur to determine that the whole operation of intermediary/carrier is a separate business that could stand on its own so that a living could be made out of the medicare-medicaid auditing for the Social Security Administration and for the insurance companies? Might not the insurance companies spinoff this responsibility so that you would not be in effect dealing with an insurance company that is auditing its own accounts plus auditing the Social Security Administration accounts. Do you see what I am getting at?

Mr. Tierney. Yes. I don't think any such organization is in existence today. I do foresee, Mr. Brown, talking about 10 years from now, whether medicare is expanded or whether we have national health insurance or whatever, that there may well be a real push toward regionalization of a great deal of the operation of this sort of thing.

I think Blue Cross itself, with 75 independent plans scattered all over the country, is giving thoughts in terms of their own business, that we can't have 75 people each trying to run their own little computer or keep their own books, and are hoping to regionalize.

I know this is the thrust of the National Association of Blue Shield Plans. I would think that perhaps the day would come when, just as we do in the cash benefits payments of Social Security Administration, we have six huge payment centers around the Nation, and the job is done there.

I think this is going to gradually evolve in a program as large as medicare, particularly to the extent that it is coordinated with medicaid, and there are many other further developments of Federal spending. But at the moment, I don't know of any such organization.

Mr. Brown. More than that, what I am suggesting is the possibility that an individual would have membership in Blue Cross or Mutual of Omaha or some other plan and can go into any hospital. They will accept his membership like a credit card.

The hospital then sends its bill not to the carrier but to an auditing agency, which then approves or disapproves the bill and our company pays it.

In other words, Blue Cross would spinoff this auditing service and combine the auditing service with the auditing service that Mutual of Omaha must carry on its accounts, and the Social Security Administration must carry on its accounts so that the auditing service would be as a separate entity from the hospital plan, whether the hospital plan is a Federal plan or a private plan.

Now, can you determine whether economically that is a practical possibility?

Mr. TIERNEY. It seems to me to be impractical from the point of view of our present mechanism of reimbursement.

All auditing is done on a retrospective basis. Blue Cross does not, as a part of its auditing process, except in the establishment of interim rates with providers, do any auditing as bills come in except on the basis of medical necessity.

They don't determine whether the amount of the bill is or is not appropriate, because in the final analysis they are going to be paid on the basis of the reimbursable cost formula. That kind of auditing comes along later, and is done largely by independent auditing firms, but I don't see, sir, how you could get any advantage out of injecting a new factor or organizational structure into the present flow of things.

Mr. Mayne is calling to my attention the common audit program that we are attempting to develop, primarily for medicare and medicaid, but hopefully through the years with a common cost report form and a common audit, there could be used by all third parties, whether private or public.

But this, too, at the moment would not be on a bill process flow basis, but on a retroactive cost audit basis.

I am not sure that there is any way to inject another entity into this picture now.

Mr. BROWN. I am feeling around here in the dark in the hope that there would be some system whereby hospital costs could be kept at their most economic and most efficient level so that the cost to the ultimate consumer could be held down by being developed on actuarially pure basis with a middleman determining proper costs, rather than the carrier/intermediary, who is also the party who charges the ultimate user a shared cost of the facility and determines whether the hospitals are operating as efficiently and economically as they should.

Mr. TIERNEY. Well, that is a part, at least a byproduct, Mr. Brown, of the proposals now being discussed in the Ways and Means Committee, of getting off of this cost reimbursement and going on to a prospective rate, target rate determination, set either through appropriate local rate commissions or whatever other mechanisms might be established.

Once that was done, so that you are off all this retroactive cost adjustment and audit, and working on the basis of proven, predetermined, reasonable charge structures, I think a lot of these problems would go away.

Mr. BROWN. I don't want to pursue the point longer, but it seems to me that it does not make sense for you, as the insuring party, to use another insuring party's auditing services. But it may be highly inefficient for you to develop your own auditing service, just as I think

it is inefficient for all the various private insurers now to have their own auditing service. It just adds to the total level of cost of hospitalization.

It just seems to me to be one more added layer of costs, and I don't know what you—meaning the Social Security Administration—can do to beat down the costs that Blue Cross has here, short of going in and saying that they should convert from manual operations to ADP. And when you get into that, I am sure that they are going to look with some degree of circumspection on your recommendation that they buy an IBM system as opposed to somebody else's system as a means of doing this.

You know, we are getting very deeply into somebody else's operation, and about that point I would think that Blue Cross and some of these other private operations would say to you and the Federal Government, well, why don't you take your business elsewhere so that we can come to our own decisions with reference to our own operations.

I am trying to find some method where the service that needs to be provided could be provided efficiently without SSA having to intrude itself so heavily into commercial operations.

I don't know if there is anybody here from Blue Cross that might comment on this approach to the problem. Maybe it's an impractical suggestion.

Mr. FOUNTAIN. I might say, if the gentleman will yield, I might say to any representative of District of Columbia Blue Cross who may be here, should you care to testify at our next hearing, we will be glad to have you, in the event you have anything that you want to add to anything said here today.

Mr. BROWN. I think it would be appropriate, Mr. Chairman, to solicit the testimony of Blue Cross District of Columbia.

I would also hope that we will get testimony from National Blue Cross, and perhaps from some of the other private carriers.

This whole area is one where the experience of anybody who is in the field would seem to me to be contributory to a solution of the problem.

We are all apparently feeling our way along, both the Federal Government and to a great extent these private carriers who have had somewhat more experience than the Federal Government has had, although not as much as on other activities.

When you are talking about this whole business just being one that developed in the last 20 years, maybe we have got a long area of evolution ahead of us in this, and I would certainly hope we would find some better ways to do it.

Mr. TIERNEY. I am sure that Blue Cross and others would be happy to come.

Mr. FOUNTAIN. I think we can get some beneficial testimony from private operations and Blue Cross. We do want to avoid duplication as much as we can, because I know many of these will probably be testifying before the Ways and Means Committee. In fact, we have been coordinating with the Ways and Means Committee. A copy of this record will be made available, as soon as it is transcribed, to the Ways and Means Committee.

Mr. BROWN. I would like to make one other observation if I may, and it is this. Our audit of your audit of Blue Cross's audit in the District of Columbia has raised some points of criticism of how you

all have exercised your responsibility with reference to the apparent fact that the District of Columbia Blue Cross auditing system is a costly one, whether, as noted earlier, because of loading on to the SSA program a portion of its costs, or because it just simply is not an efficient operation.

At least by the fact that somebody else is auditing the system, we know that it may be out of line, and we have something to compare it to. If this is transferred as a function of the Social Security Administration requiring Social Security to totally audit the medicare program, I don't know how we will ever get any comparable figures that will enable us to, as a committee of the Government, determine whether or not Social Security Administration is conducting such audits efficiently.

We know that the money we are spending in the District of Columbia for this audit is a little higher than it is apparently elsewhere in the country. If we turned over that function of auditing the District of Columbia Blue Cross to Social Security Administration, we would have a comparison with what is done by private carriers elsewhere in the country. But if we turn over the whole system of auditing to the Social Security Administration, we may never be able to compare.

Mr. TIERNEY. If I give you the impression that the Social Security Administration is looking for that function, I would like to clarify it. We are not.

Mr. BROWN. I am not suggesting that you are. I am suggesting that it is one of the conclusions to which somebody listening to the hearing may happily jump to, that we could cure this by turning it over to Social Security and hiring a lot of clerks and building a new building down here in the District someplace, and put in a new ADP system, and let them do all the auditing. And my guess is that we would find after 2 or 3 or 4 or 5 years that instead of being 50 percent out of line, we would probably be 120 percent more expensive, and we wouldn't be able to really find out because there's no way to compare it.

I am hopeful that we can find a way to make this whole thing as efficient, and as economical as possible partly because we want to spend the taxpayer's money as efficiently as possible and partly because we would like to see the cost of health care held down as much as possible. That is what we are after, really.

Mr. TIERNEY. I would only like to say, to clarify the record, Mr. Brown, if there is any need to clarify it, that any time you are dealing with 135 separate entities the way we do, intermediaries and carriers, there are going to be some very outstanding, some at the low end of the scale, and there are going to be a lot of in-betweens.

But I think it ought to be said that for the most part this intermediary/carrier system has worked effectively. There were a lot of problems and it took a lot of gearing up, and we went through a lot of headaches, but at this stage of the game, I wouldn't want to leave the impression that it isn't an effective mechanism. I think it is. But it's a mechanism that could stand constant improvement.

Mr. FOUNTAIN. Of course if you can work out a formula that is more specific, such as a negotiated contract, you can eliminate a lot of this problem.

Mr. TIERNEY. A great deal of it.

Mr. BROWN. I still think if you can find a way for the concern that is doing the intermediary/carrier auditing work to provide it out of

the savings that he could make for Uncle Sam, you would have the key to not only success for the system of intermediaries/carriers, but perhaps even for the continual effort in saving taxpayers' money.

If you come up with that formula, let me know.

Mr. FOUNTAIN. I can't help but feel that if that is done, medicare would still be less expensive than it is, because you would have competition involved, and each organization would be seeking to find the best way it could to reduce its overhead, its operations, its expenses, because it knows it would get at least a reasonable profit.

Mr. NAUGHTON. Mr. Older, would you anticipate that the charges to medicare patients in a nursing home would be larger or smaller than those to private patients?

Mr. OLDER. They should be the same, because——

Mr. NAUGHTON. I don't mean individual charges, but total charges. The services might differ of course.

Mr. OLDER. You mean the charges the nursing home makes to the patient, or the cost of medicare?

Mr. NAUGHTON. The charges to the patient. In other words, if you have 10 patients in there, and five are medicare and five private, would you normally expect that the charges to each group would be about the same?

Mr. OLDER. I would expect them to be about the same with the exception that where there are special services rendered, that are customarily charged to the patient, the charges would be so made.

Mr. NAUGHTON. I have a survey of FHA-assisted nursing homes, prepared by the Federal Housing Administration, which covers 400 nursing homes in 46 States and the District of Columbia as of January 15, 1969.

The average size of these nursing homes is 94 beds.

At the time of the survey, apparently there were 32,610 patients involved; 7,645 of these patients were Medicare, 14,675 were private: 4.6 percent of the private patients were being charged more than $900 a month; 12.4 percent of the medicare patients were being charged more than $900 per month.

Why would the medicare patients—three times as many proportionately, almost—be in that highest category of charges?

Mr. OLDER. Is there any indication in that study as to whether these are wholly certified ECF's?

Mr. NAUGHTON. I assume all of them are.

Mr. OLDER. I think we have to question whether or not they may be distinct parts.

Mr. NAUGHTON. Have you seen the study?

Mr. OLDER. No, I haven't. This is the first I have heard of it.

Mr. TIERNEY. If it is just a comparison of nursing homes with extended care facilities, I would expect exactly that result.

If they are in an extended care portion of an institution as opposed to a nursing home portion, you would expect that result.

Mr. FOUNTAIN. Regardless of who they are or where they are?

Mr. TIERNEY. The level of care which we provide in a nursing home is distinctly higher than the custodial care that most nursing homes give.

Mr. OLDER. Again it depends on whether it's a distinct part of a nursing home, one wing devoted to custodial care of old-fashioned traditional nursing home care, and another wing that takes care of ECF care as defined under law.

Mr. NAUGHTON. Let me ask you to have the cost analysis people look at this.

Mr. OLDER. May we have a copy of the study?

Mr. NAUGHTON. I am sure the FHA would be delighted to give you a copy.

One further fact—17.4 percent of the private patients were in private rooms; 6.6 of the medicare patients were in private rooms. So in terms of type of accommodation, the private patients——

Mr. OLDER. You must remember, we don't pay for private rooms. If the patient chooses a private room, he pays the difference between the semi-private and the private.

Mr. NAUGHTON. Unless it is medically necessary?

Mr. OLDER. Yes.

(The following statement was subsequently supplied for the record:)

At the request of the Intergovernmental Relations Subcommittee, we have reviewed the booklet entitled "Survey of FHA-assisted Nursing Homes" published by the U.S. Department of Housing and Urban Development.

The medicare law provides for the payment of the reasonable cost of services rendered to medicare beneficiaries; not the charge made by the particular institution. The FHA study did not indicate what the actual cost of services were in the institution in which patients (including medicare patients) were charged $900 per month.

Medicare cannot regulate or control the charging practices of participating providers. However, for cost apportionment purposes, we do have specific requirements. Under the medicare reimbursement regulation, charges to patients within the ECF must be uniformly applied to all patients in order to use the departmental RCC method of cost apportionment. In the event charges are not uniformly applied, the institutions must use the combination method of cost apportionment.

The statement on page 8 of the study (paragraph above the table) succinctly states the major reason for variations in charges.

"The degree of nursing care required or provided—ranging from intensive care to considerably lower levels of services—is undoubtedly one of the most important factors influencing the amount of monthly charges for specific patients."

Generally, medicare patients could be anticipated to be the largest single category of patents being charged at the higher charge levels because ECF-type patients (convalescent) receive the highest level of care rendered in nursing homes. Accordingly, the charges for that type of service would be the highest within the institution.

The report stated (page 3) that only 5 percent of the patients in the study were under 60 years of age. Therefore, most of the other 95 percent of the patients involved in the study would be eligible for medicare benefits assuming they qualified medically. The report also states (page 4) that approximately one-third of all the patients were categorized as convalescent-type patients compared to two-thirds chronically ill patients. Medicare patients account for 23.4 percent of all patients and presumably most of them would be categorized as convalescent-type patients.

It should be noted that the charge statistics are based upon a 1-day survey—January 15, 1969.

To be more responsive, we need to know the types of institutions included in the study and an evaluation of their charging structures. In addition, a correlation between the type of illness of patients according to payment source would be very revealing (see table 11, p. 24).

Mr. FOUNTAIN. Thank you very much. We will recess subject to the call of the Chair.

(Whereupon, at 12:30 p.m., the hearing in the above-entitled matter was adjourned, subject to the call of the Chair.)

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